COSTS AND AVAILABILITY OF LIABILITY INSURANCE

HEARINGS

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

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COSTS AND AVAILABILITY OF LIABILITY INSURANCE

MONDAY, MARCH 24, 1986

House of Representatives,
Committee on Ways and Means,
Subcommittee on Oversight,
Washington, DC.

The subcommittee met, pursuant to call, at 9 a.m., in room 1100, Longworth House Office Building, Hon. J.J. Pickle (chairman of the subcommittee) presiding.

Chairman Pickle. The Chair will ask the subcommittee to please come to order, and ask our guests to take a seat.

Today we begin the subcommittee's third day of hearings on the current crisis in costs and availability of liability insurance. We began our quest for facts and hard data on "what's wrong" and "how do we fix it" almost 2 weeks ago. We have heard already from 38 witnesses, lawyers, doctors, consumer advocates, insurance industry representatives, businessmen, State regulators and nonprofits, those who represent hundreds upon hundreds of people who are now suffering the effects of this crisis.

I am afraid this crisis might get worse before it gets better. Let's hope not. We are here today to try to begin to turn the tide against runaway and uncontrolled insurance costs.

This subcommittee still needs definitive information. The insurance industry must provide the subcommittee with more meaningful data. Tort reform advocates must tell us exactly to what extent, and how quickly, specific tort reforms will result in lower insurance costs and expanded coverage.

Our work is just beginning. There is no single villain to be blamed nor simple solution to be found. Our first 2 days of hearings demonstrate that, without a doubt. We are here today to continue our work.

I am sure our distinguished witnesses today will provide valuable observations and recommendations in this matter. I thank all of you for assisting the Oversight Subcommittee.

Our first witness today is Hon. Judge Griffin B. Bell, former U.S. Attorney General, from Georgia. Judge Bell has served with distinction in the legal profession in Georgia and as a member of the fifth circuit court, and rendered a very valuable and distinguished service here in Washington as the Attorney General of the United States.

We are pleased to have you here, Judge Bell. Originally, at this point, we were going to have a report from my subcommittee concerning findings of the President's task force on tort reform.

Out of deference to you, however, we are going to postpone that until later. I understand you got up and left Georgia early this morning in order to be here at 9. We appreciate your personal sacrifice. You may proceed, Judge Bell, as you so desire.

STATEMENT OF HON. GRIFFIN B. BELL, KING & SPALDING, ATLANTA, FORMER U.S. ATTORNEY GENERAL

Judge **Bell**. Thank you, Mr. Chairman.

Mr. Chairman and members of the subcommittee, I have been asked to testify in response to the question whether the liability insurance crisis which we are now facing in our country has been brought about in whole or in part by the tort litigation system. The answer is that it was brought about at least in part by the litigation process.

Since World War II, there has been an evolving philosophy in tort litigation based on liability without fault, the expected payment of damages by someone in case of injury, and in sums vastly larger than had ever been envisioned under any concept of predictability. The increases in damages are based on new concepts of recovery for noncompensatory damages. In addition, beginning in 1980, punitive damage awards in large sums have become commonplace.

I think it was in 1980 that the first punitive damage award of more than $1 million became a reality.

These changes have been exacerbated by the so-called mass disaster cases, which terminology is applied to cases of multiple suits arising out of the manufacture or sale of a single product, as well as situations of numerous injuries or deaths arising out of one event, such as an aircraft crash.

In the situation of the multiple suits arising out of a single product, repetitive punitive damages have been awarded in many instances, and there is no clear law as to when the total of the repetitive punitive damages awards reaches the limits of a denial of due process or even confiscation.

You can take a whole company by a repetitive punitive damage award.

These kinds of situations have led to a need for laws to provide a single forum for the many cases which may exist in the State and Federal courts over the Nation. This is a situation where you sell one product.

I have in mind, for example, the Dalcon shield product put out by A.H. Robins, with over 8,000 cases pending in the Federal and State courts, with no way to get them into one forum except in bankruptcy. We have seen Johns Mansville and A.H. Robins use chapter 11 bankruptcy proceedings in order to find a single forum. Legislation providing a single forum much as the multidistrict approach to discovery in the Federal courts is needed. Alternative dispute mechanisms could be employed in such events to facilitate dispute resolution.

Such legislation would at least restore order out of what is a chaotic situation at present. It is not clear that this would have a great deal to do with the availability of liability insurance, but it would help. It would result in fair treatment as between plaintiffs to the extent that all would have a fair chance to being paid rather than only the first in line being paid. The way it works now, there are 40 insurance companies in bankruptcy in this country, and people who had claims and were able to get a trial, and the ones that didn't get to trial, or were too late in line, just lost out. This same fairness concept would also apply in punitive damages. Provision should also be made for a class action device for punitive damages only, so that every plaintiff could share in the punitive damages pool if we are to continue awarding punitive damages to plaintiffs.

There are many suggestions as to reform of the tort system. I will be glad to answer questions about any of the suggestions that are currently being discussed. I will simply list some of the suggestions and then take questions.

The first is whether the contingency fee should be retained. I would retain it. The second would be whether the contingency fee should be reduced in some way. I would not object to some reasonable scale adjusted to the amount of the recovery. Many Americans with valid claims would be deprived of lawyers by the complete elimination of contingency fees.

There is some agitation to modify strict liability so as to make clear that plaintiffs must prove fault in order to recover. I do not think that I would change our present strict liability system at this time.

Punitive damages is a problem, and I would cap punitive damages or require a reasonable ratio between compensatory damages and punitive damages. I would also provide that punitive damages be paid, since they amount to fines to the State or Federal Government, as the case may be. I would give a small percentage of the recovery to the plaintiffs' lawyers who brought about the recovery.

There is a case called *Aetna* v. *Lavoie,* L-a-v-o-i-e, which was argued on December 4, and not yet decided. In that case, Aetna sold a group hospital policy in Alabama. There was a claim for a $3,000 hospital bill, and Aetna paid about $1,400 of the $3,000 and refused to pay $1,600.

There was a suit against Aetna to recover the $1,600 plus punitive damages, and the jury gave $3.5 million in punitive damages. That was affirmed by the Supreme Court of Alabama and the Supreme Court of the United States granted certiorari, and they are now considering whether punitive damages can amount to an excessive fine under the eighth amendment, so the committee would want to keep up with that case.

We might get some intelligence on punitive damages that way.

I think that we might well put a cap on damages for some of the esoteric types of damages, such as loss of consortium, or mental anguish, although I do not believe that I would put a cap on damages for pain and suffering.

Insurance companies have learned to predict rates based on pain and suffering. We have had that in the law for a long time.

I do not favor reducing awards by collateral sources of compensation for the same injury.

This is a big thing now with the insurance companies. They want to reduce whatever award you are claiming by anything you may have collected from another source; that sort of thing.

I do favor a restriction on joint and several liability to ensure that the defendant responsible for the injury bears a percentage of the judgment that is in proportion to his degree of fault. This should be a nationwide restriction.

When I say that, I mean that the Federal law ought to require a certain national standard or the Federal law becomes applicable.

There is an analogy to be drawn between saying that the State law would have to meet a Federal standard, and you can examine the Federal wiretap statutes and see that the States have to comport with the Federal standards, and they even file reports with the Federal Court Administrative Office to show what State wiretaps there have been and all you have to do to use State wiretaps is to comply with a Federal standard.

You could have that approach to joint and several liability. You could also have a uniform statute of limitations.

Now, plaintiffs bring cases all over the country looking for a favorable statute of limitations. It is nothing for someone from Texas to go into Minnesota, for example, to file suit.

That is forum shopping, and that can be dealt with by a national statute of limitations on product liability cases.

I do favor some restriction on discovery and it is very clear that some of the high costs of insurance stems from overuse of discovery.

Two recent studies, one in the Robins litigation and the other in the asbestos litigation, seem to indicate that the victim gets little more than a third of each dollar paid out by insurance companies while the lawyers get the balance.

Defense lawyers seem to be compensated in about the same amount as plaintiff lawyers. It is clear to me that a payments system of this kind which is so inefficient that it costs almost two-thirds of each dollar paid for the expense of transferring the money, will not suffice in an enterprise system based on efficiency, as we have in this country.

I do believe that in addition to some better way to handle major disasters, that we might also make better use of alternative dispute resolutions and exercise more discipline when disposing of insubstantial claims in court.

Some of the problem in the high cost of litigation and insurance results from the high cost of defending cases. Insurance companies pay amounts to settle which are somewhat equated with the cost of defense, and this means that often frivolous and insubstantial claims are settled for more than they are worth. This causes more frivolous and insubstantial claims.

In my judgment, there will have to be more cases tried to break this pattern.

I will be glad to take questions.

Thank you, Mr. Chairman.

Chairman PICKLE. Judge Bell, we thank you very much for your statement. I observe that you have made several recommendations, as well as stating your positions on some of the suggestions that have been offered by the various groups.

I appreciate your very candid and very forthright review of these problems, and your own individual attitudes toward them. This is so helpful to us.

I would like to ask you a few questions. When you recommend that there be a national statute of limitations for product liability actions to stop forum shopping, I assume that you are talking about a practice where you go from State to State to try to find the best deal, the best area for no limitation.

Now, if you did have a national statute of limitations to put a stop on this national Federal statute, would this be an invasion or extension of jurisdiction by the Federal Government into the control of the insurance industry?

Judge BELL. I don't think so. My view is that—there are certain national standards needed to protect interstate commerce and one is the national statute of limitations and the other is some amendment to joint and several liability.

If those two things were done, you wouldn't have to have a uniform product liability law as the Senate is considering. There is a problem just in these two areas.

As I suggested, I don't think you would have to do more than have a controlling Federal statute which the States can meet if a State has a different standard.

States would pass their own laws, then. It is nothing now for a lawyer to get 500 or more cases, and most of the time, the suits are brought where the lawyer lives, and plaintiffs may live all over the country.

This is a new phenomenon that has hit the law.

Chairman PICKLE. The President's task force, this working group, has made some recommendations and pointed out that some vast changes ought to be made in the tort system, and that biggest problem we have is in that area.

They are careful to say that that ought to be handled on a State-by-State basis. They do not recommend that we have any Federal extension of authority into those matters, and they do not make a specific recommendation, except to handle it on a State-by-State basis.

Do you think that the Federal Government should extend jurisdiction in the insurance industry or try to handle this on a State-by-State basis?

Judge BELL. I wouldn't bother the insurance industry necessarily. The States do a good job of regulating insurance companies, but we do need these national standards.

We sent people to Philadelphia in 1787 to a meeting because we couldn't control interstate commerce. That was one of the big problems and the law varies so much from State to State.

This *Aetna* case in Alabama is a good example. Aetna had $3.5 million punitive damages awarded, but to take an appeal in Alabama, a defendant is penalized 10 percent of the amount of the verdict if unsuccessful, so you have to be prepared to pay a large sum of money even to appeal in that State.

It is a burden on interstate commerce to have these variances in the law, as I see it. I don't see how insurance companies can predict rates, if there is no uniformity.

Chairman PICKLE. Well——

Judge BELL. On the statute of limitations.

Chairman PICKLE. Well, the insurance companies claim that it is very difficult to set a rate when they can't determine the degree of predictability, and that is understandable. Yet, they do predict a degree of liability because they do set rates.

Judge BELL. They are not too successful in doing it apparently, and I say that, I don't represent any insurance companies, so I don't know anything about the rates business.

Chairman PICKLE. Of course, the unpredictability of insurance is a serious question. We do know that the insurance industry made over $7 billion after they had considered their premiums and net investment costs, so I don't think that they have lost money, but I don't want to argue the fact that they are not entitled to a profit.

It has been pointed out that their income is even less than the median level of the Fortune 500 groups, but at the same time, it seems to me that a legitimate area to explore also is the insurance industry itself. So far, the committee that has made this recommendation, touches only on the tort problem.

That is something we ought to look into. I am going to yield at this time to some of the other members, but I would like to come back to you, Judge.

Judge BELL. Let me add one thing. I said I didn't represent any insurance companies; I meant casualty. We do represent one or two life insurance companies, and they predict pretty well what their rates are.

Chairman PICKLE. Mr. Anthony.

Mr. ANTHONY. Welcome, Judge Bell.

I have pulled out six things that kind of jump out from your testimony. You don't come in here and trash the current tort system like many of the insurance representatives did, saying that is what needs to be done.

Yet, when I asked them, what class of insurance premiums will be lowered and what types of policies would be available, they said, "Oh, no, I can't promise you that, but at least rates will be stable." That is the word that jumps out, trying to put some stability into the judicial system and in rates.

How would we carve out, on a national basis, or make recommendations to the States, to carve out small and large claims?

Judge BELL. Well, I will just give you my idea. I was chairman of the American Bar committee that studied the tort system, and came to the conclusion it was a good system. We have probably the best tort system in the world, but we said it needed fine tuning, and that is why I am not for making any radical changes.

We have to go to a way where you file a claim with the State insurance commissioner, and getting something like a suit letter.

You do that now in the employment cases, and that would mean then you could mediate your claim. Then after that, if you couldn't mediate it, you arbitrate or file it in court.

I start out on a smaller scale. There is a model for that, and in several Federal courts, they have an arbitration plan that we put in when I was Attorney General on an experimental basis, and it is working well. If a case involves less than, say, $25,000, they will send it out for arbitration, and if you are dissatisfied with the award, you then go back to the court system.

Mr. ANTHONY. State-by-State basis?

Judge BELL. State basis. It is something the committee might very well recommend.

Mr. ANTHONY. I have some sympathy for the insurance companies in the exposure area here, the large claims.

Judge BELL. They are going to be handled about like they are now, in my judgment, but insurance companies could give more thought to trying to work out an alternative dispute resolution system.

It is gaining widespread use right now, but I have not seen much of that going on in the tort system.

Mr. ANTHONY. You mentioned four things that could have a stabilizing effect on large claims, a single forum. Normally, when you have a multitude of claims, especially in product liability cases, you have consumers scattered all across the United States.

If we decided to go to a single forum, where would that forum be located?

Judge BELL. I argued the case of *Robins* before seven Federal judges, called the Multi-District Litigation Panel, and asked them to name a judge under the statute to handle discovery, in a multi-district situation.

Then I suggested that we transfer all the Federal cases pending in the United States to that one judge, and they could pick a judge in any district where Robins was doing business. The panel could have done that under the Federal statute.

They said they didn't have the power to do that, to have all these cases transferred. I argued if they didn't do that, Robins would probably end up in bankruptcy, using chapter 11, so they could get a central forum. Once they got into chapter 11, the court could cover State and Federal cases. It would be an easy matter for the Congress to expand the multidistrict statute to allow the transfer of Federal cases and even State cases to a single forum where you have multiple cases arising out of the sale of a single product.

Mr. ANTHONY. You also mentioned a statute of limitations. Where would you pick the time, if you have Minnesota, Texas with another timeframe, where would you throw the dart and hit the magic number?

Judge BELL. I don't know. Any reasonable statute of limitations, as long as people know what it is, the same anywhere. I wouldn't have it too short. You wouldn't want to exclude any claim until the injury was discovered.

Mr. ANTHONY. Also you mentioned punitive damages. Are you aware of any State that has a law would define it as a fine, and it would go to the State?

Judge BELL. No; but four States that do not have punitive damages.

Mr. ANTHONY. I understand Alabama doesn't have even compensatory damages.

Judge BELL. I never understood the law in Alabama. I hear the lawyers over there saying that they have punitive damages which are really not punitive damages in wrongful death cases, but somebody said recently that the law has been changed.

There are four States that do not have punitive damages, I can give you those: Louisiana, Massachusetts, Nebraska, and Washington do not allow punitive damages.

In 41 States, punitive damages are awarded to punish and deter behavior. A straight fine and the punitive damages, and the concept of fine traces back to the Magna Carta, all the way through the English common law.

Mr. ANTHONY. That is very interesting.

Judge BELL. In Connecticut, Michigan, New Hampshire, those three States at least, punitive damages are part of the compensation to the plaintiff, and therefore, the amount of punitive damages has to bear some reasonable relationship to the compensatory damages in those States, so you have three different ways to go on it.

I came up with the idea, giving punitive damages to the State, used it in a seminar somewhere, and I was surprised that the plaintiffs and defense lawyers both thought that was not a bad idea.

Mr. ANTHONY. You need to suggest that to the Members of the Senate also.

Last question, joint and several liability, you do recommend that the other tort reform ideas that have been mentioned basically stay intact with some modification on a sliding scale for contingency fees, joint and several liability, should be changed, and you would make this a national standard?

Judge BELL. I would.

If it was on a State level, it would be in so many different forms, nobody would recognize what it was.

Mr. ANTHONY. These changes would need fine tuning and would provide some stability and better working of the tort system?

Judge BELL. I think it would solve the problem, actually.

Mr. ANTHONY. Thank you very much.

Thank you, Mr. Chairman.

Chairman PICKLE. Mr. Schulze?

Mr. SCHULZE. Thank you, Judge Bell, for your testimony.

Judge, several of the members of this panel are trial lawyers. When I talk to individuals around the country and say we would rather have this solved at the State level, they say there is no way, the trial lawyers are too strong in this State to get substantial legislation through.

Do you have any thoughts on that?

Judge BELL. That the trial lawyers are against the changes?

Mr. SCHULZE. Yes; in your testimony you said, two-thirds of the compensation is going to the attorneys?

Judge BELL. I think that embarrasses lawyers. I have represented plaintiffs and defendants. I am in an organization, the American College of Trial Lawyers, in fact, I am the president of it.

It is made up of plaintiffs, defense lawyers, prosecutors, and criminal defense lawyers.

We have the whole bit, and I am not speaking for the organization, we never voted on it, but I am with a lot of lawyers, and lawyers are embarrassed at the high cost of producing damages.

Mr. **Schulze**. Melvin Belli said this is the golden age of torts. I asked him, because all the gold went in his pocket?

Judge **Bell**. Golden age for the lawyers, not for the victims.

Mr. **Schulze**. Have we gone too far? Are we overcompensating?

Judge **Bell**. The rules of discovery have made the defense lawyers, made that practice into a fine business, because you get paid by the hour to take depositions, file motions, and that is a lot of where the expense is coming from.

On the plaintiffs' side, the verdicts have gotten larger and there is no effort to scale down the fee.

Above a certain amount, you ought to scale it down. I would give the first $100,000, a third, and to the next 100, I would give 25 percent, and the next 100, I would drop down to 20 percent, and after that, I would perhaps go to 10 percent, and there would be a lot of complaining about that, but you could do it almost any way that seems fair.

Mr. **Schulze**. It would still be a fair amount of money?

Judge **Bell**. Oh, yes; I testified as an expert witness in the Beverly Hills fire cases. I represented plaintiffs' lawyers as an expert witness on the fees, and about half the cases, as I recall, went in State court, and half went in Federal, and the lawyers did a great job.

They brought about 1,200 lawsuits and produced a fund of some $20 million and they had the problem of who was going to get the contingency fee.

The court wanted to give the litigation committee, which was 12 lawyers, something extra and they were awarded 20 percent. The court—Federal and State sitting together—cut the other lawyers to 10 percent although they had contingency fee contracts of one-third.

The lawyers did a great job and the *Beverly Hills* case was a wonderful case of the tort system in action.

Mr. **Schulze**. Is there a way we can convince the trial lawyers and the insurance industry to perhaps sit down and work out some kind of a solution, because they are really pointing the finger at each other here?

Judge **Bell**. Same way with the plaintiffs' trial lawyers and the doctors. We just had a big fight in the Georgia Legislature and it was between those two groups.

It reminded me of what I heard a judge say once in court. The lawyer wouldn't sit down, and the judge finally told him, you remind me of a hippopotamus at a water hole who wants to take all the water.

He said, "Let somebody else talk some." It is a good thing that the Congress is looking into it and representing the public interest.

The judiciary committees in the State legislatures ought to all be looking at this and representing the public.

The public interest is what is involved in this. This shortage of insurance is quite a serious problem, not the cost so much as in a lot of instances, you can't get any insurance at all.

Mr. **Schulze**. That is why it has become a political problem. Would some kind of national or Presidential commission be helpful in this instance?

Judge **Bell**. It could be, and I appeared before a commission in Kansas that is studying the problem of malpractice.

Six years ago, they said when I was there, and I heard them say this, that they couldn't get any malpractice insurance at all in Kansas.

The insurance commission there brought about the creation of a State fund, and since then, I think they said one insurance company had began to write malpractice insurance but they had a commission going, and I was impressed with the commission.

I appeared before them, gave them some ideas that I had.

The insurance commissioner had a fine name, his name was Bell. He could tell you what they are doing.

Mr. **Schulze**. OK, we will look into that.

Judge **Bell**. I don't know that I would make it representative of the groups, you wouldn't get anywhere. It would have to be somebody that had no self-interest in it, if you are going to do it.

Mr. **Schulze**. Thank you, Judge Bell.

Chairman **Pickle**. Judge, a couple more questions.

Overall, in today's business and judicial world, do we have too many frivolous lawsuits, too many high awards, too many bad doctors?

What is the overall problem in this insurance industry?

All at once, individual businesses cannot get insurance, nor can municipalities. It is a national problem now. I don't know that we could point to any one thing, but overall, what is the best way for us to go about trying to find an answer?

Do you have any advice for this committee?

Judge **Bell**. I don't know. I have thought about the problem for several years of the frivolous lawsuit. I asked a lawyer once in a small town in Georgia how he was coming on with his law practice. He had taken his two sons into his practice; he replied, "We are making a fine living defending insubstantial lawsuits." That tells you a lot.

He meant frivolous, easy to win, a lot of suits, expensive to dispose of them, and there needs to be some way to carve out those kinds of cases.

That is where I would send them to something like a special State panel and dispose of those by mediation in some way, and not treat them as a big case.

Once they get into the litigation mode, into the court, they all get expensive. I don't know how to stop anybody from filing.

Federal Rule 11 of the Federal Rules of Civil Procedure was amended 2, 3 years ago. It says you can't file a pleading without having probable cause.

There have been about 1,000 sanctions hearings in the Federal courts. You can get this figure from a study that has just been made by the Litigation Section of the American Bar.

I think I saw just the other day that there has been about a thousand of these sanctions hearings, so there is something going on in the Federal court to try to bring it under control.

Judges are very reluctant to impose sanctions on lawyers, particularly about bringing a lawsuit. If there is any reason on earth to have brought the suit, it is very unlikely that anybody will do anything about it.

Chairman PICKLE. I notice that your specific recommendations in the Federal field would establish some kind of a limitation or a cap by virtue of this forum approach. That would require us to set up some kind of a Federal standard, to say that at least, with regard to product liability, there would be——

Judge BELL. That is where most of the problem is coming from now. There is also a big problem in this massive litigation that arises out of takeover matters and that is why it is hard to get liability insurance in these areas, because of the high cost of settling these stockholder derivative suits.

Chairman PICKLE. In most of these other areas, you are saying we ought to have some changes, but at the State level, State courts, State regulators.

If that is the case, then the responsibility for the State courts must be to act quickly. One question——

Judge BELL. Let me add something right there.

Chairman PICKLE. All right.

Judge BELL. One of the shortages in our country is useful statistics, and the States are all operating separately. There is probably not good data on a lot of these problems. People just think there is a problem, but they are not certain.

You can always get the Federal court data, but there is a unit over at the Justice Department that keeps statistics on criminal law, started 4, 5 years ago.

You might look into assigning them the job of keeping civil statistics, and then break it down on a computer, and finally, you would know what the facts are. I don't think that there is any way now to get the facts.

You can ask the insurance companies, and the States, but to have a national data base on the kinds of claims, what it costs to dispose of claims, how much it takes to dispose of the claims, those sorts of things, I doubt there is any good data, but the Justice Department unit over there could be charged with collecting that.

Chairman PICKLE. One other question, and I think Mr. Anthony wants to follow through, too. You point out that punitive damages are a problem, and you would recommend putting a cap on the punitive damages, or at least you would say require a reasonable ratio between compensatory and punitive damages. You make the suggestion that since punitive damages amount to a fine, they be paid to the State or Federal Government, as the case may be.

Now, I have not heard that recommendation before. How do your attorneys feel about that? That is kind of like a bombshell.

Judge BELL. I brought it up at a seminar, and the lawyers didn't object. They all thought it was a pretty good idea.

When you think about it, punitive damages is nothing more than a fine.

Why is the fine not paid into the Treasury, like any other fine?

I can't find a fine any higher than $1 million in the Federal Code on a crime. There may be something higher than $1 million but I have not found it.

A.H. Robins paid some $20 million in punitive damages one time after another until they went in bankruptcy, and it goes to individuals, and at some time, some court will say that is all they need to pay, that due process has ended this, and then the people that still have claims pending won't get a penny.

Give it to all of the people in the form of paying it into the State treasury, and you are still punishing the people who are doing what they did wrong.

You can't argue against it, really.

Chairman PICKLE. Do you think the State bar association would oppose that?

Judge BELL. Oh, they might. I wouldn't try to predict.

It wouldn't make any difference if they did. After all, they are representing lawyers. You are representing the public.

I am approaching it from a public standpoint.

Chairman PICKLE. That is a very interesting recommendation.

Mr. Anthony.

Mr. ANTHONY. Mr. Chairman, two quick questions.

Judge Bell, you said that you would not change the present strict liability system at this time. Many other witnesses have come in and said that is one of their key points for tort reform.

Judge BELL. It has just gotten into the law the last 20 years and seems to me to be working pretty well.

It is sort of an extension of the res ipsa locquitur doctrine, and the defendant knows more about the accident, that is the approach.

There has to be some compelling reason to change it. I don't believe that has a whole lot to do with insurance rates, but it might.

If somebody could show me it had something to do with the high cost of insurance, then I might change my mind.

Mr. ANTHONY. I don't think any of the insurance people that have testified have made any connection between changing the tort system and premiums reduction and insurance availability. They were specifically asked that question and given an opportunity to provide data. It hasn't been forthcoming, and their testimony does not reflect it.

They said it will stabilize premiums in the future. I have said they will anyway, because they have taken all the blood out of this turnip they can get.

The problem is, Are we going to have people continue to go bare and have no coverage? This is the problem.

Judge BELL. There is the problem.

A lot of hospitals don't have malpractice insurance, for example.

Mr. ANTHONY. Judge Bell, we also had a lot of people come in and suggest the elimination of the collateral source rule, saying an injured party shouldn't be compensated by multiple payers.

You said at the present time you would not favor reducing the awards there.

Judge BELL. It offends me to think that if I buy insurance that covers me in case I have an accident, that I have got to go, and I can sue for the cause of my injury, that I have got to take the money that I paid in insurance premiums to get and give that as a reduction on whoever injured me. That offends me.

I don't believe that will pass anywhere.

Mr. ANTHONY. It is not going to pass with my vote. You are the first person who has really come in and pierced the veil of what actually happens.

If some other party takes advantage of it, they are taking advantage of a separate transaction that they were really no party to.

Judge BELL. Certainly, it would be like a windfall. There are things wrong with the system, but that is not one of them.

Mr. ANTHONY. You have taken a logical and commonsense approach to this. You have made a very valuable contribution to the record. We will take a close look and see what the Supreme Court does with that case.

I think that is truly part of the problem. One of our other panels we had Mr. Nader, a trial lawyer over here, representing the American Trial Lawyers Association.

And we had the people representing the existing tort systems here and the insurance people there. They all talk in hypotheticals, but nobody can really come to grips with any concrete analysis.

And the Rand study is the only one anybody has been able to come up with that was really only two areas in the country. They extrapolated out from that.

Maybe trying to hold these hearings and get some data base would do more to help the consumer than anything else.

Judge BELL. So much self-interest is involved.

Mr. ANTHONY. I will be happy to go home and tell the people somebody was here representing the public as a witness.

Chairman PICKLE. Judge Bell, we thank you very much for your testimony. We appreciate that you would come up and share your feelings with us today.

The next panel is Frank Cooksey, John Satagaj, Ray Groves, and David Dalton. Will you four gentlemen take a seat, please.

The Honorable Frank Cooksey, the mayor of Austin, TX, the gentleman on my right; and the next gentleman will be John. S. Satagaj, president of Small Business Legislative Council. Am I saying that correctly?

Mr. SATAGAJ. You have got it perfectly.

Chairman PICKLE. Ray J. Groves, chairman of the special committee on accountants legal liability of the American Institute of Certified Public Accountants; and David Dalton, president, Real Estate Securities and Syndication Institute, on behalf of the National Association of Realtors.

We are pleased to have you four gentlemen.

I am going to recognize Mr. Cooksey, who is the mayor of my city, Austin, TX, and who has given us great service.

Mayor, we are particularly pleased that you would come up and share your feelings with us today.

Gentlemen, we are going to ask you to condense your testimony into 5-minute segments, if possible.

We have five panels today. We ask your cooperation on that.

Mr. Cooksey.

STATEMENT OF FRANK C. COOKSEY, MAYOR OF AUSTIN, TX

Mr. COOKSEY. It is wonderful to be here, and I want to compliment you for addressing this very important topic at this time.

I am Frank Cooksey, a part-time lawyer and full-time mayor of the city of Austin, TX.

I think that first of all, I want to address some of the issues that have faced the city of Austin in this area in the last few months.

Since May 1985, the city has operated without municipal liability insurance. Claims and suits are being settled using city funds.

While we do not expect the insurance industry to bear all the city's risk of loss, we do need liability insurance to cover the cost of catastrophic losses.

Without liability insurance for catastrophies, the city of Austin could be required to rely on its internal funding or taxing authority to cover a loss of major proportions.

What can the city do? We cannot stop the construction of major public facilities, for example, although we have been forced to pay substantial sums as a result of the awards against contractors of streets, parks, or utility projects because of the contingent liability exposure the city faces.

Can I tell the citizens of Austin that we can no longer provide nursing care for our emergency room or abandon the construction of a badly needed pediatric wing on our city-owned Brackenridge Hospital serving a 10-county central Texas market?

Will our citizens agree to abandon our parks, our swimming pools, and our softball fields because the risk is too great?

Austin's current position of complete self-insurance has arisen because the city of Austin was unable to renew the needed high levels of liability insurance we carried in the past.

In early 1985, the city began working with our broker and consultant to renew liability, public officials liability and police professional liability coverages that provided $50 million in protection for the city at a cost of under $350,000.

Under this coverage, the city paid all losses under $500,000 per occurrence and the first $500,000 of any loss. The coverage was comprehensive and offered specially tailored provisions for our diverse operations.

Two days before renewal, we learned that the many reinsurers participating in the layers of insurance were pulling out of the package, leaving only $5 million in place. The cost for the remaining $5 million was $600,000 and did not include many needed endorsements.

Hospital coverage was quoted separately with a $1 million self-insured retention and a cost of $600,000 for $5 million in limits. The total cost to the city for $5 million in coverage was $1.2 million, and this would have been for more restricted coverage, with the city paying for most claims and settlements under the self-retention limit. We did not think this was a good buy for the city and we declined to purchase.

The city went back to the marketplace with insurance specifications that we believed would be more attractive to the insurance market, because the city would increase its retention limit to $5 million. The city had never paid over $1.2 million for any one settlement and the potential for piercing the $5 million self-insured retention was very slight. Even so, there were no bidders at this new level.

The decision of the Nation's underwriters to avoid Austin could not have been based on Austin's own claims history. During the past 2 years, there was no significant change in our claims experience.

The only reasonable conclusion, therefore, is that Austin's inability to obtain insurance is related not to any experience unique to Austin, but rather to overall trends in the insurance industry.

Furthermore, certain factors indicate that Austin's experience is not based on experience peculiar to Texas. For example, Austin owns and operates Brackenridge Hospital, a general hospital and regional trauma center. We were told that this was a major deterrent to our ability to obtain coverage because of the potential for catastrophic damages in hospital malpractice cases.

However, it is well established in Texas that municipal hospitals are covered in the Texas Tort Claims Act, which provides a limitation of liability of $100,000 per person injured, and $300,000 per occurrence. This limitation, which effectively excludes all hospital operations from any coverages, under any policy we sought, was not considered by underwriters, who apparently look only at national levels and national trends.

By focusing on our excess liability coverage, I do not mean to imply that the remainder of our insurance portfolio was satisfactorily priced. This year, costs for airport coverage increased sevenfold from under $35,000 for $100 million in limits to close to $300,000 for the same limits, with more restricted coverage.

City property insurance costs doubled, resulting in a new premium of $880,000 for 1986 compared to $445,000 for 1985. In 1984, the city paid $248,000 for the same coverage.

Is the city of Austin a poor risk? No; I don't believe so. Our claims experience is good. Our liability carriers made no payments under the policies either in settlement or litigation. In fact, our city has been recognized within the State as a leader in accident prevention.

A risk management program was implemented in 1983 to identify and address risks in our operations. No; I don't believe the city of Austin per se is a poor risk.

The problem extends beyond the city and the State of Texas. It has become a national problem, and as such, merits our attention.

If you have not seen the Time magazine this week, pick up a copy. It has got your topic of conversation on the front page.

Chairman PICKLE. We saw that last Friday. It was called to our attention; yes.

Mr. COOKSEY. This situation is compounded by the difficulty our service providers are also having in obtaining insurance.

Small contractors, local firms, and nonprofit organizations that provide valuable services to our city are not able to obtain or afford minimal levels of insurance that protect them and the city against liability. They are calling on us for help as they face escalating premiums or cancellations.

Our day care programs in the city of Austin, for example, are affected by this problem.

What is the impact of this liability crisis on the citizen of Austin? Sickle cell anemia clinics may close, the miniature railroad that transports families through our major park may stop, and local minority contractors may no longer be able to afford to bid on city projects.

In addition to a reduction in services, taxpayers will also bear the brunt of the insurance crisis through reallocation of program dollars to pay for settlement and premium increases. The impact on our citizens will be measured in dollars and cents as well as a reduction in the public services they have come to enjoy in Austin.

Our citizens are turning to us, the policy makers, for guidance and direction in this crisis. In Austin, we are not sitting back. We are taking positive steps. We have agreed to a much higher level of self-retention and have begun setting funds aside from operational funds to secure this retention.

We are reviewing all major exposures in the city to identify ways to minimize our risk. Safety programs are continuing to ensure that our employees understand our commitment to providing services and operations in a safe environment for both the employee and the public.

We can take these steps, but they are not enough. The insurance industry, Congress, and State legislatures must also take positive steps to address these problems and provide a responsible solution.

I am a lawyer and I have great respect for the plaintiffs' attorneys, and for those who represent the defendants and insurance companies, but I believe some modest changes in the present system are necessary.

As you are aware, of course, the Joint Committee on Liability Insurance and Tort Reform of the Texas Legislature has focused on this problem at the State level. The committee has not yet made any recommendations for State legislative action. We are hopeful, however, that the Texas Tort Claims Act will be amended to extend governmental immunity to our proprietary functions. This will be a major step toward improving the current crisis situation.

We are going to be happy to work with you in any way that we can to develop solutions to this liability insurance crisis, and we thank you very much for the opportunity to appear here today and offer our comments and give you some data about the effect of this very difficult situation on the cities of the United States.

I would add that both the U.S. Conference of Mayors and the National League of Cities as well as the Texas Municipal League have defined this as one of the major crises facing the cities of America today.

Thank you.

[The prepared statement follows:]

REMARKS BY THE HONORABLE
FRANK C. COOKSEY, MAYOR
CITY OF AUSTIN, TEXAS

Mr. Chairman and members, ladies and gentlemen. I would like to thank you for the opportunity to talk with you today on a subject of great concern to me as Mayor of the City of Austin. I am honored that Austin was selected to testify on behalf of Texas municipalities before this distinguished Subcommittee.

First, allow me to tell you a little bit about Austin.

The City of Austin is a dynamic, growing city of 437,000. Like most cities our size, our municipal government offers a range of fine public services--- police and fire services; acres of parks and recreation facilities; street and road repair and libraries. The City of Austin also offers many other services, some rare among cities--- electric utility; wastewater facility; a major hospital; and a nationally recognized emergency medical service.

The rendition of these services presents the possibility of some risks. Herein lies the problem I wish to address today.

Since May, 1985, the City has operated without municipal liability insurance. Claims and suits are being settled using City funds. While we do not expect the insurance industry to bear all the City's risk of loss, we do need liability insurance to cover the cost of catastrophic losses.

Without liability insurance for catastrophes, the City of Austin could be required to rely on its internal funding or taxing authority to cover a loss of major proportions.

What can the City do? We cannot stop the construction of major public facilities, for example, although we have been forced to pay substantial sums as a result of awards against contractors of streets, parks or utility projects because of the contingent liability exposure the City faces.

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The City went back to the marketplace with insurance specifications that we believed would be more attractive to the insurance market, because the City would increase its retention limit to $5 million. The City had never paid over $1.2 million for any one settlement and the potential for piercing the $5 million self-insured retention was very slight. Even so, there were no bidders at this new level.

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Furthermore, certain factors indicate that Austin's experience is not based on experience peculiar to Texas. For example, Austin owns and operates Brackenridge hospital, a general hospital and regional trauma center. We were told that this was a major deterrent to our ability to obtain coverage because of the potential for catastrophic damages in hospital malpractice cases. However, it is well established in Texas that municipal hospitals are covered in the Texas Tort Claims Act, which provides a limitation of liability of $100,000 per person injured, and $300,000 per occurrence. This limitation, which effectively excludes all hospital operations from any coverages, under any policy we sought, was not considered by underwriters, who apparently look only at national trends.

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We will be happy to work with you in any way we can to develop solutions to the liability insurance crisis.

CITY OF AUSTIN
LIABILITY CLAIMS EXPERIENCE
1981 - 1984

YEAR	NUMBER OF CLAIMS FILED AGAINST CITY	TOTAL COST OF CLAIMS AGAINST CITY
1981	376	$ 292,199
1982	402	633,050
1983	323	302,871
1984	449	648,473

CITY INSURANCE PLANS
1981 - 1986

LIABILITY

YEAR	LIMITS	PREMIUM	COMMENTS
1981	$300,000 Per occurrence	$ 30,342	Applies to claims from water works, sewer, golf course, auditorium, and library operations
1982	$300,000 also $5 million public officials	$ 46,216	Added public officials for planning commission
1983 Umbrella	$50 Million excess of $500,000 per occurrence	$215,000	"Umbrella", all operations
Public Officials	$500,000 each claim	$ 12,973	Errors and omission
Police	$500,000 each claim	$ 88,900	Covers claims from police professionals
Workers' Comp.	$50 Million excess of $500,000 per occurrence	$ 50,000	Stop loss for Workers' Compensation claims
1984 Umbrella	No change	$225,000	No change
Public Officials	No change	$225,000	No change
Police	No change	$ 98,764	No change
Workers' Comp.	No change	$ 98,764	Dropped deductible to $250,000
1985	All coverages except Workers' Compensation stop loss coverage unavailable		
1986	All coverages except Workers' Compensation stop loss coverage unavailable		

CITY INSURANCE PLANS
1981 - 1986

AIRPORT

YEAR	LIMITS	PREMIUM	COMMENTS
1981	$20 Million Per occurrence	$ 10,087	No deductible
1982	No change	$ 10,087	No change
1983	$100 Million Per occurrence	$ 31,218	No change
1984	No change	$ 31,218	No change
1985	$100 Million	$ 31,218	No deductible
1986	$100 Million	$296,186	$50,000 aggregate deductible. Personal injury limits of $2.5 million. Excludes pollution claims.

CITY INSURANCE PLANS
1981 - 1986

FIRE AND EXTENDED COVERAGE

YEAR	LIMITS	PREMIUM	COMMENTS
1981	$552.3 Million	$513,109	Actual cash value 90% co-insurance. Deductible - $100,000 (Electric), $10,000 (Other property)
1982	$200 Million Per loss	$311,328	Replacement cost policy. $100,000 deductible "All-risk" form
1983	$200 Million Per loss	$248,476	Added extra expense EDP coverage, valuable papers
1984	$200 Million	$248,476	No change in coverage
1985	Blanket ($1 Billion)	$445,678	All-risk coverage $100,000 deductible replacement cost basis
1986	Blanket ($1 Billion)	$880,000	Added business interruption for H P & L Contract

CITY INSURANCE PLANS
1981 - 1986

BOILER AND MACHINERY

YEAR	LIMITS	PREMIUM	COMMENTS
1981	$25 Million Per accident	$449,234	Deductibles range from $50,000 to $600,000 depending on equipment. Lower limits at non-utility location
1982	$40 Million-Utility $ 5 Million-Non-Utility	$343,610	No change
1983	$40 Million-Utility $ 5 Million-Non-Utility	$343,610	No change
1984	$40 Million	$197,650	$100,000 deductible - Utility, $ 10,000 non-utility
1985	$40 Million	$197,650	Deductible - $100,000 (utility) $10,000 (non-utility)
1986	$40 Million	$255,628	No changes

CITY INSURANCE PLANS
1981 - 1986

EMPLOYEE BONDS

YEAR	LIMITS	PREMIUM	COMMENTS
1981	$100,000 Faithful performance for 12 positions. $5,000 dishonesty all other employees	$ 12,310	Coverage applied to primarily financial positions
1982	No change	$ 12,310	No change
1983	$100,000 Faithful performance $1 Million employee honesty	$ 12,310	Coverage extended to all employees
1984	$500,000 Faithful performance $4.5 Million honesty $5 Million depositors forgery	$ 32,807	$5,000 deductible added
1985	No change	$ 32,807	Coverage for all employees
1986	No change	$ 32,807	No change

Insurance cost, scarce policies squeeze cities

September 10, 1985

By Peggy Vierebome
American-Statesman Staff

City employees in West Lake Hills are being told to be especially careful because the city has not been covered by insurance since Aug. 31.

The City of Dallas received only one bid — with a premium of $1.7 million — on its insurance this summer. The former policy premium was $157,000.

The Travis County budget director expects a large increase in the county premium — currently $150,000 a year — when bids for liability insurance are opened Tuesday. That is, if anyone bids.

Throughout the state and the country, local governments are finding it difficult, expensive, or impossible to get insurance. Citing declining profits, insurance companies nationwide are tightening up on who they will insure, and for how much.

"Cities are undesirable in their eyes," said Francis Fey, assistant director of a Texas Municipal League unit that manages a self-insurance pool for cities. "They are afraid of the risks."

As a result, some local governments have had insurance canceled, others have received no bids for insurance coverage, and some have received prohibitively high bids for less coverage.

Dallas officials, after rejecting the bid with a $1.7 million premium, declined to buy insurance, and instead use self-insurance, which the City of Austin has used for years.

Instead of covering all risks by buying insurance, Austin puts money in a kitty to cover claims and judgments. In recent years, when the cost of insurance policies was low, Austin bought policies and cut back on the self-insurance pool, said Geri Joskowitz, risk manager for the city.

But as the insurance market changed, the city turned increasingly to self-insurance. The City Council set aside $1 million this summer as the first of several yearly allocations to build up a pool to pay for "catastrophic

A catastrophic claim or settlement is one that is more than $300,000, a liability limit set by state law in most instances. One such suit was filed against Austin this year. The suit seeks $35 million for the death of an 11-year-old child in a car wreck on Clawson Road. The suit, filed under a law that sets no limit on liability, said the city knew Clawson Road was dangerous, and should have done something about it.

Usually a city can budget for large court judgments or suit settlements because the cases take years to go through the court system and may be paid over several years, Joskowitz said.

However, self-insurance is not financially practical for small cities like West Lake Hills, said Dick Hargarten, city administrator.

West Lake Hills is applying to the self-insurance pool managed by the risk and insurance management service of the Texas Municipal League. The application joins others filed by cities without insurance.

"They are being canceled so fast they have just been flooding in," said Fey of the Texas Municipal League.

Normally, 10 cities apply each month to join the pool, which manages insurance coverage for 215 of the 900 cities in Texas, Fey said.

Last month, applications from 30 to 40 cities were added to a stack of 100 waiting to be processed, he said. Like West Lake Hills, more than half of the waiting cities have no insurance, Fey said.

The 3-year-old self-insurance service, with $12 million in the premium pool, is the largest in the nation, Fey said.

Judgments and claims of up to $300,000 each are paid from the pool. An insurance company covers any amount above $300,000 through a policy called reinsurance.

Because so many cities are without insurance coverage, pool managers decided Tuesday to enable cities to buy the basic $300,000 coverage instead of waiting until the full coverage is secured, he said.

Insurance

From B1

Two major causes for the insurance crunch are large payouts on claims and declining interest rates.

Referring to industry figures, Fey said claims and expenses have risen to a point where insurance companies are paying out an average of $1.50 for every $1 they collect in premiums.

Meanwhile, lower interest rates mean insurance companies are getting less return on the investment of premiums.

When interest rates were high during the past five years, premiums were low as insurance companies competed for business. Sometimes insurance companies took a loss on premiums, but made it up with investment income, Fey said. That cushion no longer is available.

"Since they need to cut their losses and concentrate on being profitable businesses again, they are getting out of high-risk" coverage, Fey said.

The inability of cities like West Lake Hills to get insurance appears to have nothing to do with their history of claims.

The West Lake Hills policy expired Aug. 31, and a five-month search for an insurer was fruitless. The city was left without coverage in the event of suits arising from police arrests, accidents involving city property, or decisions made by city leaders.

West Lake Hills had been paying $12,000 to $15,000 a year for umbrella protection "into the millions of dollars," said Hargarten.

The insurance crisis began in January when many government policies were up for renewal. The crunch will get worse by next January, according to an insurance industry publication.

[illegible] Austin American-Statesman • Sunday, January 19, 1986

Liability coverage likely to continue high-priced trend

Texas board chief blames costs on insurance industry, lawsuits

By Bruce Hight
American-Statesman Staff

> Society cannot 'have affordable and available insurance, and at the same time an insurance mechanism that is called on to pay jumbo awards based on emotion.'
>
> Mike McCrery
> Insurance executive

The problem businesses, professionals, local governments, school districts and others are having finding affordable liability insurance will continue for at least two years, said the chairman of the state Board of Insurance.

Lyndon Olson said Saturday that the problem was international in scope and that the insurance industry bore a large share of the blame. He also said Americans' increasing willingness to sue each other has contributed.

"My estimation is that it will take about a year and a half to two years for the market to begin to firm up," Olson said.

But the market for environmental and municipal government liability policies "probably will not recover for years, if it ever does recover," he said.

Olson's remarks came during testimony before the first meeting of the recently appointed House-Senate Joint Committee on Liability Insurance and Tort Law and Procedure.

Lt. Gov. Bill Hobby and House Speaker Gib Lewis set up the committee after receiving a flood of complaints about huge increases in the cost of liability insurance and, with increasing frequency, the inability to renew or obtain liability policies.

Spokesmen for businesses, school districts, cities, and county governments trooped before the committee with horror stories about 1,000 percent increases in liability rates and about their policies being canceled.

Part of the problem, Olson said, grew out of the high interest rates and extreme competitiveness of the insurance industry in the late 1970s and early 1980s, when companies dropped rates in many cases simply to raise more cash for investments, which could bring high earnings.

The result, he said, was that the insurance companies "torpedoed themselves into the ground and they are trying to recover in one or two years what they did to themselves in 10 years. And they need to accept their part of the blame for this problem."

The problem is real and not manufactured, he said. In 1984, Olson said, there were 18 insurance companies in receivership in Texas; in 1985 there were 31, about half of which were property and casualty companies.

Also contributing to the liability insurance problem, he said, was the increasing number and size of judgments awarded in lawsuits or the settlements out of court forced by such suits. That, he said, has made the American market for insurance more unprofitable.

Olson refrained from making any recommendations in reforming the tort law system in which someone who is injured can sue to recover for damages.

Mi : McCrery, a Dallas insurance company executive speaking for the Association of Fire and Casualty Companies in Texas, laid the blame squarely at the feet of the tort law system.

Society, he said in his prepared testimony, cannot "have affordable and available insurance, and at the same time an insurance mechanism that is called on to pay jumbo awards based on emotion."

David Burrow, president of the Texas Trial Lawyers Association, said the insurance industry could not back up claims that overly generous jury awards or the settlement of cases out of court had actually driven up their losses.

"This crisis — if you want to call it a crisis — we submit is one that was manufactured by the property and casualty insurance industry to increase their profits," Burrow charged.

Houston Chronicle
February 18, 1985

STATE

Cities hit hard by new high insurance rates

SAN ANGELO (AP) — Insurance companies, hit by record underwriting losses in 1984, have increased rates to Texas cities by as much as 800 percent in recent months and canceled their contracts altogether on some occasions, insurance experts say.

CIGNA insurance company did not renew its coverage with Grand Prairie in October. St. Paul pulled out from Port Arthur and the city's premiums doubled in one year. Irving's premiums tripled.

San Angelo stayed with the Texas Municipal League pool insurance but is paying $169,180 more than budgeted for liability and property insurance.

Texas cities are scrambling to meet the costs but cities in other states are panicking, said Texas Municipal League Director Bill Martin.

"I get several calls a day from cities in other states that are in sheer hysteria, wanting to know how we're handling it," Martin said. "The cute euphemism that's being used is non-renewal. They can't find anything. They're naked, bare, without coverage."

Because municipal risk is traditionally considered bad business, some companies, like Aetna, are withdrawing completely. Others, such as St. Paul, will bid on property, but not liability insurance.

Cities no longer enjoy governmental immunity. A case can be taken to federal court where almost any grievance can result in damage claims under the 1983 Civil Rights Act, Martin said.

Texas has not felt the impact as much as other states because the insurance industry considers it to have a more stable local government market, Martin said.

City officials and insurance consultants said they saw the first indication of trouble in mid-1984, but were not concerned because no one expected a drastic change, said Robert Lazarus of Robert W. Lazarus & Associates Inc., a risk management and insurance counseling service in Plano.

In a few extreme cases, cities have had 500 percent to 800 percent increases. The trend is for increases of 50 percent to 150 percent, Lazarus said.

"You find a shortage of companies that insure and for those who will, they charge a high price," Martin said.

Adding fuel to the fire is a recent Texas attorney general's decision that requires cities to bid publicly for their insurance to make sure the market is competitive.

Some cities seek bids too frequently for the insurance companies' taste. The companies prefer to contract for at least three years to make a profit or recover losses, said Judson Hobby, a risk management consultant with The Wyatt Co. in Dallas.

"I think they don't like competitive bidding," Martin said. "When it gets tough, they use the opportunity to bail out."

The consultants are advising their clients to eliminate some fringe coverage, seek higher deductibles, lower coverage limits and, in some cases, to set up self insurance programs.

The costs of police and public official liability insurance have risen dramatically, Lazarus said.

The number of companies writing police protection in the United States dropped from 22 to seven in only two years, said Frances Fey, the Texas Municipal League assistant director.

Part of the turbulence in the insurance industry is attributed to an international financial situation.

Insurance companies cede part of their risk to the reinsurance market, which in turn invests in the international market where money is funneled into such investments as Arab oil and Japanese trade.

In 1983 and 1984, the property and casualty insurance business lost $33.3 billion, more than the total underwriting deficit for the previous 25 years, Martin said.

The 1984 losses were not offset by the $17.3 billion in investment income.

A series of man-made and natural catastrophes contributed to the losses. Hurricane Alicia, which rocked the Texas coast in 1983, caused $1.6 billion in losses in Houston and Galveston.

Insurance experts believe the industry shakedown will stop in two to five years and allow the system to return to relative normality.

Price Increases, Profit Reductions Are Common; Some Drop Products and Exercise Greater Caution

A WALL STREET JOURNAL News Roundup

THE INSURANCE CRISIS

THE SOARING cost and worsening shortage of liability insurance are taking their toll on businesses, professionals and local governments across the country. The crisis is forcing companies to raise prices or accept smaller profits, change their operations and eliminate products and services.

The effects vary, a survey by The Wall Street Journal shows, depending on a company's size. For most small businesses, for instance, the biggest problem seems to be rising premiums.

In an extreme case, General Motor Lines, a family-owned trucking company in Roanoke, Va., filed for Chapter 11 bankruptcy-law reorganization when it learned that its annual insurance premium would be more than double to nearly $300,000.

More typical is Seven Springs Mountain Resort in Champion, Pa., which raised the price of ski-lift tickets an average 25% to compensate for a sixfold premium increase to $828,000. Its deductible increased to $300,000 from $250. Without the higher deductible, "our premium would have been over $1 million," says a spokesman.

For big companies, which can more easily absorb higher insurance costs, the most serious problem is the lack of coverage at any price in such areas as directors' and officers' liability, pollution liability and product liability.

As a result, mutual insurance companies are being set up by the drug, chemical, railroad, utility, hazardous-waste-disposal, banking and thrift industries. Already in operation is A.C.E. Insurance Co., started late last year by 34 major companies from a variety of industries, including autos, electronics, steel, oil, retailing and entertainment. Several of the industry mutuals plan to cover claims between $50 million and $100 million; A.C.E. Insurance will cover claims exceeding $100 million.

Companies that can still find insurance are operating differently in an effort to limit premium increases. Cessna Aircraft Co. stopped making five types of small planes last year because product liability premiums, which account for as much as 30% of a plane's cost, had driven the prices of new models beyond the reach of most customers.

Kinder-Care Learning Centers Inc., the nation's largest operator of day-care centers, is putting in big windows between classrooms and hallways to reassure parents and insurers alarmed by charges of child abuse at other day-care centers. "We're putting ourselves in the posture of never being behind closed doors," says its president, Richard Grassgreen.

At one drug company, a top official says privately, department heads have been put on notice that liability suits and heavy damage claims will affect their performance ratings.

The insurance crisis is also making life difficult for many professionals. While the rising cost of medical malpractice insurance has dominated the headlines, malpractice premiums for architects, engineers and accountants are rising even more sharply.

Meanwhile, local governments are going without all or part of the liability coverage they had in the past. Some are cutting services or not offering new ones. Miami canceled plans for an experimental rail-bus line because it couldn't find insurance coverage for the project.

Lafayette County, Mo., closed its jail for seven weeks after its policy wasn't renewed, releasing 10 prisoners who were being held on minor charges and sending others to jails around the state. The jail was reopened earlier this month after coverage was arranged through a self-insurance fund set up by Missouri sheriffs.

Officials in many other places say that there hasn't been any effect. But they add that taxpayers will have to foot the bill for any future damage awards.

The immediate cause of the sharp premium increases and lack of coverage are losses that insurers suffered from competitive rate cutting on commercial property-liability policies in the six years through 1984. The companies had hoped to offset claims payments with income earned from investing premium dollars.

But by 1984, claims and administrative expenses exceeded investment income by $3.8 billion. The gap widened to $5.5 billion last year, even as premiums jumped 21% to $142 billion, because of unusually heavy hurricane damage. Even so, the industry expects to post net income of $1.7 billion because of tax credits and capital gains on stocks sold from investment portfolios.

Insurers acknowledge that many of their financial wounds are self-inflicted, but they claim a more serious problem is the rising cost of defending and settling lawsuits and paying big jury awards. "We've reached the point where losses are simply exploding," says M.R. Greenberg, president of American International Group Inc., a major property-liability insurer.

Allied with other business groups, insurance trade associations are pushing for changes in liability laws and caps on jury awards and lawyers' fees. Plaintiffs' lawyers and consumer groups, however, contend that the insurers are simply greedy and have orchestrated the current crisis to pressure Congress and the state legislatures to limit the rights of victims. (See accompanying story.)

But while that debate continues, some industries are being particularly hard hit. Here's a look at their troubles—and some of the emerging solutions. (Also included are reports on three types of coverage that cut across industry lines: for directors and officers, professional malpractice and earthquakes.

CHEMICALS

Chemical companies appear to be shying away from investments that could add to their insurance problems. Essex Chemical Corp., a medium-sized New Jersey manufacturer, says it decided last year against investing in new businesses that could present environmental hazards; its insurance costs had doubled despite a 90% reduction in coverage.

Similar problems face big chemical companies. American Cyanamid Co. says it currently can find liability coverage of only about $15 million to $50 million, compared with $200 million to $300 million previously. As a result, it joined with 33 other companies last year in forming A.C.E. Insurance, and it is exploring other industry-owned insurers.

One called Casualty Excess Assurance Ltd., will offer general liability insurance, as well as pollution and directors' and officers' coverage. Among its prospective members are Celanese Corp., Dow Chemical Co., Monsanto Co. and Union Carbide

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FINANCIAL INSTITUTIONS

The rising tide of bank and thrift failures has made liability insurance for financial institutions, particularly directors' and officers' coverage, an endangered species.

When banks or thrifts go under, federal regulators now routinely sue directors and officers to collect whatever insurance they had. Banks are suing former employees.

John B. Foley, a vice president of Alexander & Alexander Services Inc., a major insurance broker, tells of a case where an insurer covered both a thrift and its regulators. Now they are suing each other, and no matter who wins, Mr. Foley says, the insurer loses.

Insurers have responded by virtually abandoning the field, leading various bank and thrift groups to look into setting up mutual insurance companies.

The lack of coverage is making some directors more cautious. John W. Klug, chairman of San Clemente, Calif., Savings & Loan Association, says his board is aware that it's operating without insurance. "I'm sure before we undertook a risky investment or anything out of the ordinary we would discuss it at great length," he says.

Stockbrokers' difficulties center on their blanket bonds, which cover losses caused by dishonest employees. Bateman Eichler, Hill Richards, a Los Angeles-based broker, installed a closed-circuit television system in its securities vault last summer following a fourfold premium increase. (Ironically, the firm is a unit of Kemper Corp., a major Chicago-based insurer.)

HEALTH CARE

For Beverly Enterprises, a nursing-home chain based in Pasadena, Calif., higher insurance costs directly affect the bottom line. Because about 65% of its revenue is from government reimbursements, the company says it can't raise prices to compensate for a rocketing of premiums to $7.2 million from $1.7 million. "If you consider that every $500,000 is a penny a share; that's a significant increase," says James Kovacs, Beverly's director of risk management.

The company avoided a reduction in coverage last year largely because its policies were renewed early. This year Mr. Kovacs expects more difficulty, and he may buy some coverage from a captive that Beverly set up last May for workers' compensation.

Several big hospital chains, including Hospital Corp. of America and Humana Inc., have avoided huge premium increases because they use captives to handle lower levels of medical malpractice coverage. Still, they are paying more for higher levels from outside carriers. Hospital Corp. is beefing up its risk-management staff, which means added costs.

MUNICIPALITIES

People injured by police officers sometimes file lawsuits; pollutants can leak from town dumps; and official vehicles have accidents. As insurers avoid the most unpredictable risks, cities and towns are among the first abandoned.

Boston has been without liability insurance since the end of 1984, when a policy covering claims over $1 million was canceled. The city's insurer, like many others, got out of the municipal liability business entirely, says Robert J. Cioelek, deputy director for fiscal affairs. Mr. Cioelek says he considered a foreign insurer, but the city decided against buying coverage after premiums of more than $100,000 were quoted. Previously, the city paid $30,000 a year.

Wilmington, Del., dropped its liability policies this month, says finance director I.G. Cleaver, because premiums jumped 90% to $1.1 million for coverage reduced to $9 million from $15 million. "We thought it was a horrendous situation considering our excellent record," Mr. Cleaver says. The city also believes a state law will limit its liability to $300,000 per accident.

Fort Lauderdale, Fla., still has liability insurance for its police and public officials, but lacks a general liability policy that would cover accidents on sidewalks or the Intracoastal Waterway. "It's simply not available," says risk manager Ronald Torre.

At least 30 California cities are operating without insurance. Blue Lake, a lumber town of 1,200 people in the northern part of the state, limits access to public buildings and may close its roller-skating rink. "We could be wiped out" if hit with a big damage award, says Richard Platz, the city attorney.

OIL

The cost of liability insurance for the oil industry climbed by at least 50% last year, while coverage slipped substantially, executives say.

Several years ago insurers generally provided $600 million of liability coverage for a major oil company, but that figure has shrunk to about $200 million, says Edward J. Kettel, assistant treasurer of Chevron Corp. Amoco Corp. is paying two-and-a-half times as much for $184 million of liability coverage as it paid for $425 million of coverage a year ago.

The higher costs will dent oil companies' earnings, but not drastically, industry executives say. "We're not that concerned about how higher-priced insurance will affect us financially," Mr. Kettel says. "We're more concerned about the growing potential exposure" to catastrophic losses.

Philadelphia-based Sun Co. and several other oil companies say they are having trouble finding liability coverage for pollution and other health hazards. When they can find insurance, it frequently requires higher deductibles.

PHARMACEUTICALS

U.S. drug makers say most of their product-liability insurance that expired last year wasn't renewed. The few insurers still in the field are providing no more than about 15% of their former coverage and are severely limiting the types of claims they will pay. "Meaningful product-liability insurance for the pharmaceutical industry is nonexistent," says Daniel A. Cuoco, a senior vice president of Squibb Corp.

Several manufacturers say their coverage, which once ranged from $200 million to $400 million, has fallen to about $10 million to $30 million. Some premiums have quadrupled, but cost isn't the issue. "Most companies would pay whatever the underwriters want," says a lawyer for a big drug maker. "The problem is finding anyone who'll sell us anything."

Most drug manufacturers already have captive insurance units that handle their least costly claims. But if the captives are forced to handle the bulk of future claims, parent companies' earnings could suffer.

Drug makers say it is virtually impossible to avoid claims. All drugs cause some side effects, because a positive response in one part of the body almost always carries with it a negative response elsewhere. When a drug is administered to hundreds of thousands of patients, a few serious reactions can occur.

A unit of American Home Products Corp. last year stopped selling a whooping cough vaccine generally considered safe by physicians. But the product caused problems in some children, and lawsuits resulted in what the company considers unreasonably large damage awards.

As a result of such problems, only two major pharmaceutical companies, Merck & Co. and American Cyanamid's Lederle Laboratories, are investing heavily in vaccine research. And although patents for many birth-control pills have expired, few companies are marketing less-expensive, generic versions.

SERVICE INDUSTRIES

Day-care centers, hotels, restaurants, bars, ski resorts, ice-skating rinks and other service businesses face sharply higher premiums or a lack of liability coverage. While some smaller operations are closing up, others are trying to make themselves less vulnerable to lawsuits or are passing higher costs to their customers.

In addition to installing big windows in its day-care centers, Kinder-Care has developed such programs as "Buckle Up Bear," which tells tots to wear seat belts in Kinder-Care vans. The company says liability premiums jumped by $500,000 last year, or about 20%. The increase, equivalent to less than 2% of a child's tuition, was passed on to customers.

Marriott Corp. paid a 600% premium increase for coverage that was cut in half. Arnold Davenport, vice president, went to London to seek more insurance, but "we didn't come back with a lot of coverage," he says. Marriott is trying to equip all its hotel rooms with sprinklers, a safety feature insurers ask about, he says.

Hazardous-waste-disposal companies face special problems. About 50 facilities failed to meet a federal deadline last November to obtain coverage for toxic leaks, and many of them have begun closing.

Big companies fear they won't be able to renew liability policies that expire this year and plan to form their own insurer. Meanwhile premiums are rising by as much as 500% for 90% reductions in coverage. Browning-Ferris Industries Inc. in Houston will probably begin self-insuring when its policy expires in October, even though self-insurance is "a lot scarier," says Donald Lindquist, a vice president

TRANSPORTATION

Small trucking and bus companies are the hardest hit transportation concerns, but even large railroads are being squeezed.

Star Transit Bus Co., a charter operator in Trenton, N.J., was hit last August with a premium increase of nearly 270%, to $550,000 from $150,000. Although its coverage remained $10 million, the deductible rose to $5,000 per bus from $3,000.

Mitchell Sussman, president, says the company is trying to avoid riskier trips, such as ski charters. "It hurts to see the buses sitting, but we would be vulnerable to risk of accidents on icy roads," he says.

Other companies are also curtailing services or raising prices. But many complain they can't effectively respond to the insurance crisis because they're still reeling from fierce competition and price wars caused by deregulation.

The American Trucking Associations says more than 100 companies have collapsed and more are expected to fail because of increased insurance costs.

The rest are trying to adjust. Dameo Trucking Co., Somerville, N.J., recently raised some rates 3% and stopped hauling certain hazardous chemicals. But Rocque Dameo, president, says the price rise isn't enough to cover a 178% premium increase to $25,000 a year. He adds that his company, which had been slightly profitable, is now just breaking even.

DIRECTORS' LIABILITY

Several outside directors of at least six publicly held companies resigned last year because the companies couldn't obtain directors' and officers' (or D&O) liability coverage. So far, such defections have been concentrated among troubled companies in the energy, electronics and steel industries, but management consultants expect the problem to spread.

Insurance brokers estimate that as much as two-thirds of the industry's capacity to write D&O coverage evaporated last year; the reason is that insurers paid out three to four times as much in D&O claims as they received in premiums. Insurers are also rewriting policies to exclude coverage of lawsuits stemming from hostile takeover fights, by federal regulators and by a company against its own officers or directors.

When coverage can be found, premiums are going way up. Stride Rite Corp., a Cambridge, Mass., shoe company, saw its premium hit $122,000 a year from $7,000 a year, even as coverage was cut to $5 million per lawsuit from $10 million.

"We got clobbered," says John Phelan, Stride Rite's chief financial officer. The company considered covering directors itself, but Mr. Phelan says, "I would feel very, very nervous about self-insuring that kind of liability. There are too many nuts out there; let me put it another way:

PROFESSIONAL MALPRACTICE

Faced with escalating premiums for malpractice coverage, doctors began organizing their own insurance companies a decade ago. But other professions haven't faced such a major crunch before.

When Merrick & Co., a Denver engineering and architectural firm, put out bids for its professional liability coverage, it received only two. Moreover, the quoted premiums were two to five times higher than the old policy's, says the company's president, Bruce Walker.

Instead of paying those increases, Merrick cut its coverage to $500,000 from $1 million, raised its deductible to $200,000, and paid a $50,000 premium, compared with $44,000 a year earlier. The company says it didn't have much choice, because Colorado law and many contractors require insurance. Otherwise, Mr. Walker says, the firm would probably go without coverage.

Small accounting firms saw premium increases of 200% to 400% last year, and could face even bigger rises this year. A major reason is the nearly $180 million in lawsuit settlements that the industry's Big Eight firms have paid since 1980. Those firms have had difficulty renewing their coverage with Lloyd's of London.

As annual insurance premiums for obstetricians in the New York City area reached nearly $85,000 a year, some physicians said they would stop delivering babies. Meanwhile insurance brokers and lawyers are beginning to see premium increases like those of doctors.

EARTHQUAKE COVERAGE

For many West Coast businesses, earthquake coverage has become little more than a memory. "A lot of our clients have decided they can no longer afford it and have become self-insured," says Frank Kelly, a San Francisco insurance broker with Alexander & Alexander Services.

At Boas International Motors, a San Francisco Honda dealership, President Walter Mossner decided to go without coverage when he was told that a $5 million policy would cost $100,000. The expiring policy, for $4.5 million coverage, had cost only $5,500.

San Francisco still insures its $112 million Moscone Convention Center, but is paying $800,000, up from $130,000, for a policy with a $5.6 million deductible. Some large companies are buying less coverage. Pacific Gas & Electric Co. says it has about half the coverage it had two years ago.

Hewlett-Packard Co. in Palo Alto, Calif., takes a different view. It has never bought earthquake coverage, partly because its risk-management specialists aren't convinced insurers would be able to pay the billions of dollars in claims that would result from a major quake.

Chairman PICKLE. Thank you, Mayor, and I think we all agree on that last observation.

Now, we will ask Mr. Satagaj to proceed, and remind you about the 5-minute limitation. The mayor went over it just a wee bit.

STATEMENT OF JOHN S. SATAGAJ, PRESIDENT, SMALL BUSINESS LEGISLATIVE COUNCIL

Mr. SATAGAJ. Maybe I can make up a minute or two.

Chairman PICKLE. We are asking you to proceed, then.

Mr. SATAGAJ. Thank you, Mr. Chairman.

My name is John Satagaj. I am here today on behalf of the Small Business Legislative Council. Accompanying me is Bruce Hahn, of the National Tooling and Machining Association, who is chairman of our board of directors.

We are a permanent coalition of approximately 88 trade associations and our sole purpose is to represent the interests of small business. What makes our testimony so interesting is despite the fact that we have 88 associations representing perhaps 70 different types of industries, we find many issues in common by nature of our common denominator which is small business.

I can say without hesitation, liability insurance is rapidly rising to the top of the list of any association whatever the nature of the business, if it is not already at the top of the list. We in the small business community feel we are betwixt and between on this issue.

Actually our problem is simple: Insurance is a cost of doing business. When the costs of insurance doubles, triples, it takes a substantial bite out of the thin layer of income we call profit.

If you studied the profit-and-loss statement of any small firm, you know unexpected items such as this are what upset the apple cart and start the chain of events rolling which results in a business closing its doors. You never seem to catch up.

We have collected a lot of statistics and data from all our members. I have appended representative samples from five of our associations. You have another three of our member associations testifying here today.

I don't think it is necessary for me to go through the data on what is happening. I think it is very clear.

Premiums are increasing at exponential rates—50-, 70-, 150-percent increases are not unusual. Of greater concern is many firms are electing to go bare. I use the term "electing" very loosely. They really don't have much choice.

It is particularly difficult for small firms when they go bare, because there are no other options. They do not have the alternative of perhaps becoming a self-insurer so it is very difficult for them when they go bare.

I have included the results of these surveys, and we are happy to provide any data we can on how bad the situation is. But I think it is beyond that point. The question is, What we do about it?

We see many factors contributing to this problem. One is the general climate in our society.

I am sure you may have seen last night's "Sixty Minutes" story on "So Sue Me," and the theme of the story was you take a matter to court. There is always the feeling, "I am going to get mine; they can afford it"—"they" being the insurance companies.

We are very skeptical, we believe tort reform is necessary.

The size of awards, contingency fee arrangements, methodology of class action suits, and probably most important, the cause of action available to plaintiffs all add to the problem.

A plaintiff can sue just about anybody remotely involved in a negligence situation in search of deep pocket. With a broad, strict liability statute or case law, the burden of proof has been reduced substantially.

I want to caution we are not saying throw the baby out with the bath water. To be sure, there are plenty of examples of wrongs made right only because of the system we have in place.

What I am saying is, bring us back from the edge. It doesn't have to be an even balance, but we need to address the problems we are now facing in the tort system.

At the same time, we also feel there is a problem in the insurance industry. Much of our concern is rooted in the belief that industry may have taken its eye off the ball, the insurance business. Mergers, acquisitions and investments have stretched some companies further than they would like to admit.

These problems, coupled with an overreaction to isolated incidents, have pushed premiums to the current level. We do not believe our claims record justifies the current premiums.

These are the problems. Where are the solutions?

Generally, small business owners shudder at the thought of Federal regulation. It is not a concept which sits well with them.

Further, the two main contributors to the problem, the tort system and insurance regulation, have been traditional areas of State activity.

Much of the reform could take place at the State level, but I stress the "could." We have called for a national commission for quite some time. We still believe there is a place for a national commission on both the tort reform and insurance.

Our only concern about having such a commission is that it does not slow down the process. We need to move beyond the study stage. We need to move into action.

Now, the domestic policy working group on tort reform, I am sure everyone has heard now, has released its recommendations to the President and they are under consideration by him.

We endorse just about all those recommendations of the tort working group. We feel they are a very positive first step.

The question is, Would any of these recommendations solve our problems? Most likely, none by themselves would result in a solution.

Returning to a fault-based liability concept with a redefinition of joint and several liability would produce the most desirable long-term reform.

Caps on awards and legal fees would most likely translate into immediate relief and we support them, but we believe they are more symptoms of the system gone awry rather than root causes.

Can this reform be achieved in Federal legislation? Yes; but it is a qualifying question because we believe much has to be State level and even with Federal legislation, we will be working with the States on this issue.

As I indicated earlier, we believe the insurance industry has contributed to the problem as well.

First, a national commission is necessary to clarify the question of what is the appropriate role or the Federal role in insurance regulation.

On the whole, we would venture to say and I think small business are included in the class of victims and consumers, that we know less than insurance and reinsurance than we do even about the civil justice system.

We suspect such a commission would conclude the Federal Government needs to set standards for State regulation of insurance companies, the standards might range from the nature and extent of the data collected to even assuring there is adequate State regulatory staff. I understand that only 22 States of 50 have an underwriter on their staff on the insurance regulation commission, and really do not understand the underwriting problems.

What role has McCarren-Ferguson played in the act? While we believe that this act has contributed to the problem, we are not calling for complete repeal.

At the moment, we believe there is a regulatory gap and it may be necessary to define what aspects should or shouldn't be regulated by the Federal or State governments.

A separate issue which is of great concern to us in the Small Business Legislative Council is the general trend of big business in recent years to reduce competition through mergers and acquisitions. We have rarely seen a megamerger we like, and we believe the industry has participated in big business game of mergers and we are very concerned about its impact on competition and availability of insurance.

On the subject of reinsurance, we find ourselves among those who feel unsure about the best approach. It may be Federal or State participation is necessary. At a minimum, we have to explore ways to get small business into self-insurance or risk pooling or whatever may be available now to others.

Our best assessment of the situation is that reinsurance is not available, and what is available comes from foreign sources and appears to be very expensive.

But the problem is the reinsurance industry is not even regulated at this time, so you have to get to that first threshold of determining whether you can regulate the reinsurance industry before you can determine what it is you are going to do with them.

I have no magic solutions, and we know no one group should shoulder the blame for the current situation, but we do have a crisis. It is national in scope. It is a top priority for the small business community. We will do whatever is necessary.

If it is on the insurance side, civil justice, all we want is relief at this time.

Thank you, Mr. Chairman.

[The prepared statement follows:]

Testimony of John S. Satagaj, President
Small Business Legislative Council
Before the Subcommittee on Oversight
Committee on Ways & Means
March 24, 1986

It is a pleasure to appear before this Subcommittee on behalf of the Small Business Legislative Council (SBLC). My name is John S. Satagaj and I am the President of the organization, accompanying me is Bruce N. Hahn of the National Tooling and Machining Association, Chairman of the SBLC Board of Directors. SBLC is a permanent coalition of approximately eighty-eight trade associations and our sole purpose is to represent the interests of small business in national policy matters. In order to be a member of the coalition, at least 70% of an association's membership dues must be derived from small firms. Our eighty-eight members represent over four million small businesses.

One of the striking features of SBLC is the fact we represent the breadth and depth of small business. As an assembly of associations, we represent a diverse range of interests which, of course, only reflects the fact small businesses dominate almost all sectors of the economy.

What makes SBLC work, and what makes our testimony so interesting, is the fact we do find many issues in common by nature of our common denominator of small business and I can say without hesitation, liability insurance is rapidly rising to the top of the list as a concern for all small firms, whatever the nature of their business, if it isn't already at the top of their list.

Within the small business community, we have seen several issues which coalesce the community and move them to action in unison. In the mid-70's tax rates were a major concern. In the late 70's, our concern was a voice for small business and we obtained a White House Conference and laws such as The Regulatory Flexibility Act. In the early 80's we started the battle for deficit reduction. In fact, over a longer term taxes and the deficit have been the traditional one-two on our priority list.

Liability insurance has pushed its way to the top of the pack and is pulling the community together. As you may know, we are currently in the midst of regional meetings leading up to a national White House Conference on Small business this August here in Washington. At these local meetings, at least one per State, small business owners have an opportunity to vote on issues to shape an agenda for the national meeting. At the outset, certain issues categories were established and briefing papers were prepared. Insurance was not among these issues. Now some two dozen meetings later, insurance has its own session and a diverse range of recommendations have come forth from these sessions.

We, in the small business community, feel we are betwixt and between on this issue. Actually our problem is quite simple. Insurance is a cost of doing business. When the cost of insurance doubles, triples or quadruples, it takes a substantial bite out of the thin layer of income we call profit. If you have studied the profit and loss statement of any small firm, you know unexpected items such as this are what upset the apple cart and start the chain of events rolling which result in a business closing its doors. You never seem to catch up.

We have been deeply involved in identifying the source and extent of the problem since it surfaced in force last fall. We held a major conference on December 11th and heard presentations by the legal profession, the insurance industry and government. We are conducting a second national conference today and tomorrow.

Our member associations have been gathering data on their individual industries. Appended to this testimony are statements by five of our member groups. They represent a cross section of small businesses.

The surveys show a clear trend. Premiums are increasing at exponential rates. Fifty, seventy, and one hundred fifty percent increases are not unusual. Of greater concern, many firms are electing to go "bare" and forego any coverage. It is difficult to guess how long such a strategy will work. The results of these surveys demonstrate the depth of this crisis.

The individual stories bring the problem closer to home. A recent story in Newsday carried a summary of our members' stories and a copy is appended to my testimony. The litany of these anecdotes is long. One thing is certain, we can document, with hard data, the cost to stay in business.

We say we are betwixt and between because we don't believe we are a substantial contributor to the problem and really haven't heard anybody point the finger at us and say small businesses are careless. From the preliminary data we have seen, the "claims against" history for our member groups is very good.

Instead, we see several factors contributing to the problem. The first is the mind set of our society at this time. In a sense we have become a litigious society. There is always the feeling of "Well, I'll get mine, they can afford it." The ubiquitous "They" most likely translates into the insurance companies. Although the subject of insurance coverage is generally not discussed with juries, we can't help but wonder how many jurors could you find who have not had the thought in the back of their minds insurance will cover this case.

We believe tort reform is necessary. In SBLC, we have heard the trial lawyers present their case and we have listened to Assistant Attorney General Willard who heads up an interagency task force on tort reform. The size of awards, the contingency fee arrangement, the methodology of class action suits and probably, most importantly, the causes of action available to plaintiffs, all add to the problem. A plaintiff can sue just about anybody remotely involved in a "negligence" situation, and I use that term loosely, in search of a deep pocket. With a broad strict liability statute or case law, the burden of proof has been reduced substantially.

We are not saying throw the baby out with the bath water. To be sure, there are plenty of examples of wrongs made right only because of the system we have in place. We are suggesting, however, the process has outpaced the "economics" of justice. Society has to balance our individual protection against the need for a working economy. While we are not suggesting it is necessary it be an even balance, the system has pushed us too far in one direction.

We feel the insurance industry has played a role in the current crisis as well. Within our group we have heard testimony from this industry and again we come to the conclusion, the scale is not completely broken but is out of balance. Much of our concern is rooted in the belief the insurance industry might have taken its eye off the ball-the insurance business. Mergers, acquisitions, and investments have stretched some companies further than they would like to admit. These problems, coupled with an overreaction to isolated incidents have pushed premiums to the current level. We do not believe our claims record justifies the current premiums.

These are the problems we see, but where do the solutions lie? Generally, small business owners shudder at the thought of federal regulation. It is not a concept which sits well with them. Further, the two main contributors to the problem, the tort system and insurance regulation, have been tradition areas for State activity. As such we believe much of the reform could take place at the State level, but stress the could.

This is now a national problem, and demands national attention. We believe we must explore the possibilities of Federal action both for tort reform and insurance regulation. As early as September we had called upon the President to set up a National Commission to develop recommendations for action. We still believe such a National Commission is necessary, not to determine whether a problem exists since we believe we are beyond that point, but to serve as a panel of experts to sort out various proposed solutions. Press reports indicate the President is predisposed to endorse the recommendations of his Domestic Policy Council on tort reform. Certainly a National Commission would provide some impetus for those efforts but it should not delay the process of enacting legislation to bring about relief for beleaguered small businesses.

The report of the Domestic Policy Working Group recommends:

Recommendation No. 1: Retain Fault as the Basis for Liability

Recommendation No. 2: Base Causation Findings on Credible Scientific and Medical Evidence and Opinions

Recommendation No. 3: Eliminate Joint and Several Liability

Recommendation No. 4: Limit Non-Economic Damages to a Fair and Reasonable Amount

Recommendation No. 5: Provide for Periodic Payments of Future Economic Damages

Recommendation No. 6: Reduce Awards by Collateral Sources of Compensation for the Same Injury

Recommendation No. 7: Schedule Contingency Fees

Recommendation No. 8: Develop Alternative Dispute Resolution Mechanisms

Each of these recommendations have merit and we anticipate we would support implementation.

Would any one of these recommendations solve our problems? Most likely none by themselves would result in a solution. Returning to a fault based liability concept with a redefinition of joint and several liability would produce the most desirable long term reform. Caps on awards and legal fees term would most likely translate into immediate relief and we support them, but they are symptoms of a system gone awry rather than root causes of it.

Can tort reform be achieved through Federal legislation? Yes it can. There are bills already before this Congress to achieve such goals and the President's Working Group envisions a Federal legislative initiative. Should this Congress pass such legislation? A qualified yes is our response. Our qualification is based on our belief this side of the problem, a civil justice system out of kilter, was created primarily at the State level and should be solved there. Quite frankly, however, if we are to gain relief in our lifetime we must have Federal action. Even with Federal legislation, we will still need State action to achieve completely true tort reform.

As I indicated earlier, we believe the insurance industry has contributed to this problem as well. First, a National Commission is necessary to clarify the question of what is the appropriate role of the Federal role in insurance regulation. On the whole, we would venture to say less is known about insurance and reinsurance than about the civil justice system.

We suspect such a Commission would conclude the Federal government needs to set some minimum standards for State regulation of insurance companies. Standards might range from the nature and extent of data collected from companies, regulation of premium levels to more accurately reflect costs, or ensuring adequate State regulatory staff expertise in areas as underwriting.

What role has the McCarron-Ferguson Act played in creating the problem? While we believe it has contributed to the problem we are not prepared to say outright repeal is the answer. At the moment we believe there is a regulatory void and it may be necessary to define what aspects should or should not be regulated by the Federal or State governments.

A separate issue is the general trend of big business in recent years to reduce competition though merger and acquisitions. Historically, SBLC has seldom seen a mega-merger it liked. We cannot help but wonder whether the insurance industry, which we understand has participated in the merger/acquisition game, couldn't stand closer antitrust scrutiny.

On the subject of reinsurance we find ourselves among those who feel unsure about the best approach. It may be Federal or State participation is necessary. At a minimum we believe self-insurance activities and "risk pooling" should be encouraged.

Our best assessment of the current circumstances with respect to reinsurance is that there is limited availability of this type of insurance. Most of what is available is from foreign sources and appears to be prohibitively expensive and perhaps overpriced with respect to actuarial risks. Many in the reinsurance industry blame the U.S. tort system for the problem.

As a first step since this type of insurance is not subject to regulation under current law, it would be difficult to require any improvements that might be desirable unless a regulatory scheme is enacted. While we do not presently have specific improvements to recommend, we believe that this line of inquiry should be pursued by the Committee because the circumstances suggest that substantive improvements can be made.

We have no magic solution and we know no one group should shoulder the blame for the current situation, but we do have a crisis.

We are willing to meet anytime to find solutions but there is little we can do without help. The sources of the problem are not under our direct control. We need your assistance, otherwise this problem will result in severe damage to the small business community.

Thank you for this opportunity.

MEMBERS OF THE SMALL BUSINESS LEGISLATIVE COUNCIL

Alliance of Independent Store Owners and Professionals
American Association of MESBICs
American Association of Nurserymen
American Consulting Engineers Council
American Dental Trade Association
American Subcontractors ASsociation
American Textile Machinery Association
American Trucking Associations, Inc.
Amusement and Music Operators Association
Architectural Precast Association
Associated Equipment Distributors
Association of Independent Corrugated Converters
Association of Physical Fitness Centers
Association of Small Business Development Centers
Association of Small Research, Engineering and Tech. Service Companies
Automotive Service Councils, Inc.
Automotive Warehouse Distributors Association
Building Service Contractors Association International
Business Advertising Council
Chicago Gift Show Inc.
Christian Booksellers Association
Direct Selling Association
Electronic Representatives Association
Florists' Transworld Delivery Association
Furniture Rental Association of America
Greater Washington Ibero-American Chamber of Commerce
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Independent Bankers Association of America
Independent Insurance Agents of America, Inc.
Independent Sewing Machine Dealers Association
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International Franchise Association
International Reciprocal Trade Association
Jewelers of America

Latin American Manufacturers Association
Machinery Dealers National Association
Manufacturers Agents National Association
Marking Device Association
Menswear Retailers of America
National Association for the Self-Employed
National Association of Aircraft and Communication Suppliers
National Association of Brick Distributors
National Association of Catalog Showroom Merchandisers
National Association of Chemical Distributors
National Association of Development Companies
National Association of Home Builders
National Association of Manufacturing Opticians
National Association of Minority Contractors
National Association of Plastics Distributors
National Association of Plumbing-Heating-Cooling Contractors
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National Association of Retail Druggists
National Association of Small Business Investment Companies
National Association of the Remodeling Industry
National Association of Women Business Owners
National Candy Wholesalers Association
National Council for Industrial Innovation
National Electrical Contractors Association
National Family Business Council
National Fastener Distributors Association
National Grocers Association
National Independent Dairy-Foods Association
National Moving and Storage Association
National Office Products Association
National Parking Association
National Precast Concrete Association
National Shoe Retailers Association
National Small Business Association
National Small Business Government Contractors Association
National Society of Public Accountants
National Tire Dealers & Retreaders Association
National Tooling and Machining Association
National Tour Association
National Wine Distributors Association
Opticians Association of America
Petroleum Marketers Association
Power and Communications Contractors Association
Retail Floorcovering Institute
Retail Tobacco Dealers of America
Smaller Manufacturers Council
Small Business Council of America, Inc.
Society of American Florists
Specialty Advertising Association International
United Bus Owners of America
United Federation of Small Business
Urethane Foam Contractors Association
Web Sling Association

Automotive Service Councils, Inc. 188 Industrial Drive, Suite 112 Elmhurst, Illinois 60126 (312) 530-2330

DIRECT REPLY TO:
Donald A. Randall, Washington Attorney
321 D Street, N.E.
Washington, D.C. 20002 Tel. (202) 543-1440

LIABILITY INSURANCE DATA
FROM AUTOMOTIVE SERVICE COUNCILS, INC. MEMBERS
January 28, 1986

Results from a survey of 143 members produced the following information:

I.*	Total members with premium increases	55.24%
A.	Premium increased without change in coverage or carrier	31.47%
B.**	Premium increased; owner forced to reduce coverage to afford insurance	16.08%
C.	Premium increased, owner went to different carrier for lower rates	7.69%
II.	Insurance company decreased coverage	.70%
III.***	Insurance company cancelled policy	41.26%
A.	Insurance company cancelled policy; owner got new carrier at a higher premium	21.68%
B.	Insurance company cancelled policy; owner got new policy with a different carrier but with less coverage for a higher premium	10.49%
C.	Insurance company cancelled policy; owner presently has no coverage	6.29%
D.	Insurance company cancelled policy; owner obtained coverage with another carrier for a lower premium	.70%
E.	Insurance company went bankrupt, moved, etc.; owner forced to seek new carrier	2.10%
IV.	Owner happy with insurance carrier & reports no premium increase or cancellation	2.80%

* Average premium increase out of 115 owners who reported an increase (not including effective increases where premium increased accompanied by decreased coverage) 42.44%

Highest premium increase	164%
Lowest premium increase	4%

** Average coverage decrease of 19 owners who reported decreasing coverage 31.69%

Highest premium decrease 90%
Lowest premium decrease 7%

*** Based on owner-responses, the following insurance companies would not insure them at **any** cost.

1) Onion Group, Inc.
2) West Bend Insurance Co.
3) State Farm
4) SAFECO
5) Kemper
6) Nationwide
7) Chicago Insurance Co.
8) Consolidated American
9) Valley Pacific
10) Farmers Company
11) General Accident
12) Travelers Insurance Co.
13) Royal Insurance Co.
14) Trans America
15) Midwestern Insurance Co.
16) Pennsylvania Manufacturers Assoc.
17) United Community
18) Harleysville Insurance Co.
19) Statesman's Insurance
20) Fireman's Fund
21) Ohio Casualty Group
22) Fireman's Mutual
23) UCIC

FOR FURTHER INFORMATION, CONTACT DONALD A. RANDALL
WASHINGTON REPRESENTATIVE, AUTOMOTIVE SERVICE COUNCILS, INC.
202/543-1440

NMSA

T. Peter Ruane
President

NATIONAL MOVING AND STORAGE ASSOCIATION

"Over 60 Years of Service to the Moving and Storage Industry"

IMPACT OF INSURANCE CRISIS ON THE MOVING AND STORAGE INDUSTRY

The nation's Moving and Storage Industry is suffering from the "Liability Insurance Crisis" as is the trucking industry in general. Because of its unique organizational structure and small business characteristics, the "crisis" if it continues could become a financial disaster for the moving and storage industry.

Through its participation in numerous regional meetings during the last three months, the National Moving and Storage Association (NMSA), has identified the insurance liability crisis as the number one problem facing the small business segment of the moving industry.

Our experience mirrors the situation of general trucking and other impacted activities. Astronomical rate increases, cancellations without cause and lack of availability are commonplace. Although we cannot identify the average rate increase for the industry during the past year, horror stories abound.

A representative of a major van line recently indicated he expected their insurance rates to be doubled. During the last week one of our larger association members (West coast) related his experience. For this member, last years premium was approximately $300,000. Being aware of the insurance turmoil and recognizing a substantial segment of his business is conducted in Alaska, he anticipated an increase to $650,000. After extensive researching their broker placed the business at $1,200,000 (a 400% increase).

The NMSA office receives frequent calls from members seeking coverage at any price. The moving service is regulated by the federal and state governments, each of whom require liability insurance as a condition of retaining operating authority. Consequently, the moving industry does not enjoy the option of going "bare." It is illegal!

Because of the unique organization of the moving industry: van lines - agents - owner operators costs invariably are passed down to the small business level, the agents and/or owner operator. It is at this level the crisis can become a disaster.

124 South Royal Street, Alexandria, VA 22314
Phone: 703/549-9263
TELEX: 901803 NMSA WASH

NMSA

NATIONAL MOVING AND STORAGE ASSOCIATION

"Over 60 Years of Service to the Moving and Storage Industry"

T. Peter Ruane
President

Small movers are denied alternatives available to large corporations. They cannot entertain high deductibles to reduce premium levels, nor command the resources to become self insured. In most cases even collective group action has been unobtainable.

A state movers association (South) workers compensation liability insurance pool was forced to close recently because of lack of reinsurance to the group.

The moving industry apparently is able to place cargo insurance. It is in auto and other liabilities; general, Directors and Officers and the like that the crisis exists.

The theory of insurance is basically sharing of a risk. When liability insurance cannot be obtained, the mechanism for small businesses to share a risk is non-existent. The economic well being of a key component of the nation's economy is threatened.

The causes of the crisis are complex, but certainly a fundamental cause is the functioning of our tort-law system. Whether the fault lies with the judicial, the legal fee systems, the "deep-pocket" syndrome or federal law, NMSA recommends that a full review of the tort-law system is in order. Concurrently, a review of the effectiveness of state insurance regulation should be undertaken and if it is found lacking, federal oversight initiated.

124 South Royal Street, Alexandria, VA 22314
Phone: 703/549-9283
TELEX: 901803 NMSA WASH

NATIONAL TOOLING &
MACHINING ASSOCIATION

9300 LIVINGSTON ROAD, FT. WASHINGTON, MD 20744 301/248-6200

TO: John Satagaj, President
Small Business Legislative Council

FROM: Bruce N. Hahn, CAE

SUBJECT: SBLC Liability Insurance Questionnaire

DATE: January 28, 1986

I very much appreciate your offer of using NTMA survey results from the SBLC liability insurance questionnaire in SBLC's testimony before the House Commerce Subcommittee hearings on liability insurance on February 4, 1986. We've had an excellent response (over 200 so far). In order to get some preliminary data to you in the most timely fashion, we counted off the first fifty and tabulated them. Based on those fifty responses from our members (small manufacturers, typically 15-20 employees), the results were as follows:

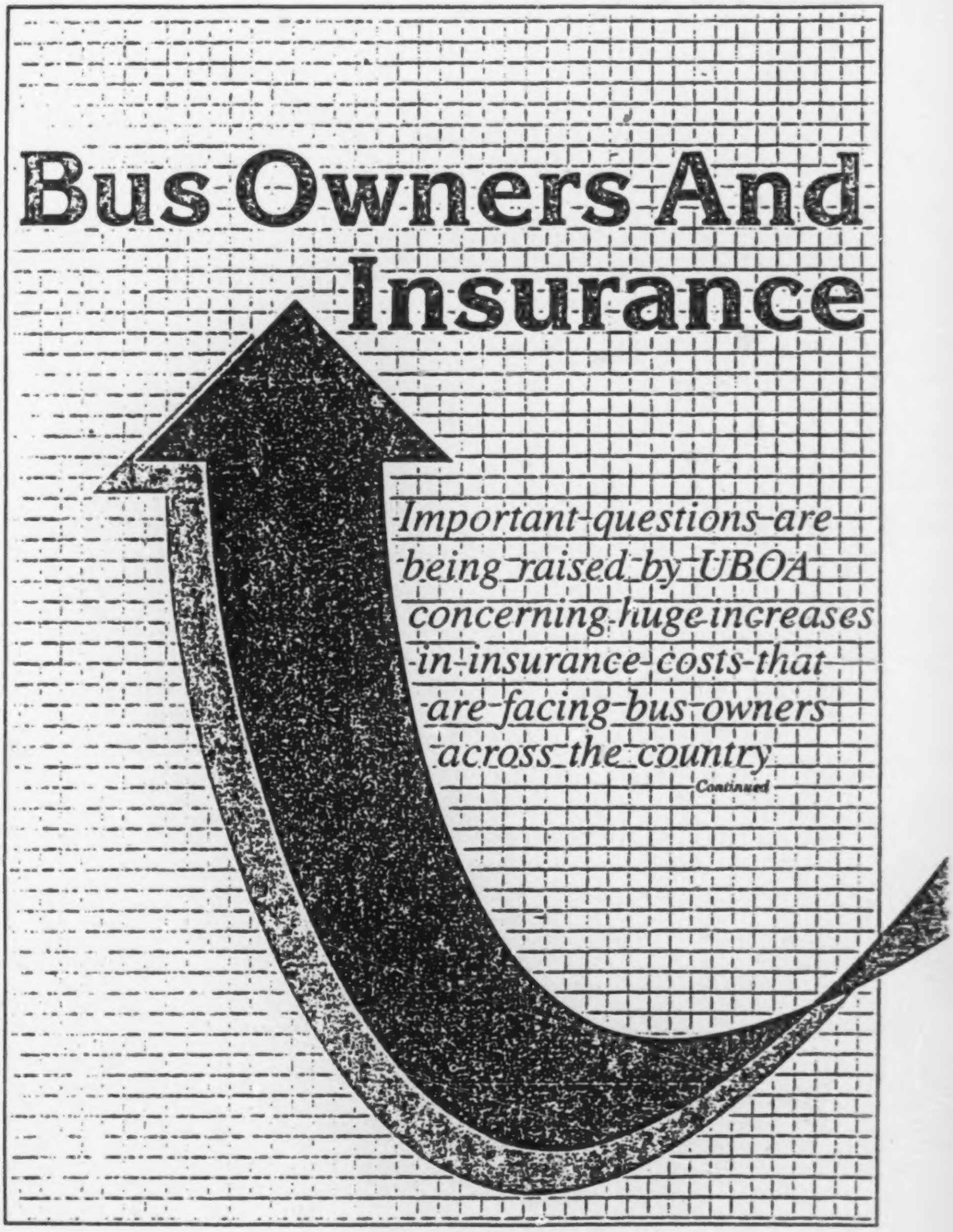
1. Average 1985 premiums $ 9,455 (46 observations)
   Average 1986 premiums 16,474 (46 observations)
   % increase 74.2%

2. Number of companies having recent claims -
   2 out of 45 (4.4%) (average claim $466)

3. Average premium for those changing carriers -
   1985: 4,714
   1986: 7,924
   average increase 68.1%

4. Number unable to get liability insurance at any price -
   3 (6%)

BNH/mw
cc: Matt Coffey
Lee Ryan
Frank Langway



Bus Owners And Insurance

Important questions are being raised by UBOA concerning huge increases in insurance costs that are facing bus owners across the country

Continued

Editor's note: The following article was prepared by Wayne J. Smith, executive director of United Bus Owners of America. It relates the concerns of bus owners, many of whom have struggled recently to find affordable insurance, as well as actions by UBOA to draw attention to the problems involved and seek solutions.

* * * * *

We did it to ourselves; we shot ourselves in the foot. At least that is the way some in the insurance industry see it.

Were it not so, how could a person testifying for the American Insurance Association say that, even with enormous rate increases, "The current loss ratio continues to reflect the likelihood that losses . . . will exceed premium collected"? Notice the word "current," which must be taken to mean right now, after the increases already have been imposed.

James L. Kimble, senior counsel, was the person testifying for the American Insurance Association before the Subcommittee on Surface Transportation of the U.S. House of Representatives on October 30. He addressed the Bus Act separately, but seemed never to come to grips with the extent to which bus owners are responsible for what is declared to be 41 percent outlay in excess of income for "commercial auto" insurance during 1985.

The experience of United Bus Owners of America (UBOA) has been that our program has been a consistent money-maker for insurance providers; we have not imposed losses on providers.

During the Subcommittee hearings, probing questions were directed toward James Kimble. Subcommittee Chairman Glenn Anderson (D-Ca.) spoke from direct experience in the insurance business, and seemed not to be satisfied with the answers.

The congressman heading the subcommittee minority, Bud Shuster (R-Pa.) said, "We have not received testimony today to justify the increase in insurance costs for buses and trucks." Shuster conceded that the insurance industry, as a whole, may face a real problem, but he could not "see that the transportation industry had contributed (to the problem)."

The insurance industry said that loss ratio is affected strongly by "loss adjustment expenses (principally legal defense costs)." Congressman Thomas D. DeLay (R-Tx.) asked when the industry would reverse that loss trend, and when it would begin to "fight frivolous suits." DeLay said lawyer acquaintances had told him they make it a practice to take insurance cases to court, knowing the industry will not fight the claims.

UBOA told Anderson's subcommittee: "During the past few years, UBOA's premiums approximated $58 million annually. Losses incurred during each such period were below 50 percent, resulting in a profit for the insuror."

By contrast, the insurance industry said its losses for commercial auto liability coverage ranged from 109.7 percent in 1980 to 144.3 percent in 1984.

UBOA's testimony did not dispute overall losses; we simply objected to being lumped into the loss listing. We said:

"For the insurance industry as a whole, however, insurors suffered losses when pay-outs exceeded premium income during the insurance price wars that began in 1980. In the face of bus industry losses, insurors naturally chose to concentrate their efforts on areas posing lower potentials of risk than does the motor carrier industry. Even though UBOA's program was profitable to the insuror, we were caught up in the decision of the insurance industry to shift to populations offering greater security

Continued

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Bus Owners

Continued

against catastrophic loss. Put differently, insurors decided that if they were to exit the motor carrier industry, it would be done across the board, rather than on a selective basis; that UBOA's program, however healthy, could not be immune to the quarantine against high hazard coverages."

Things may get worse before they get better, but at least we're getting sympathetic attention.

Chairman Anderson suggested on October 30 that, legislatively or procedurally, his group may be expected to face up to the insurance problem's prejudicial impact on the motor carrier industry. Just one day earlier, Chairman John C. Danforth (R-Mo.) of the U.S. Senate Committee on Commerce, Science and Transportation spent more time on insurance than on any other aspect of the Bus Regulatory Reform Act of 1982. The hearing had been called to examine the results of passage of that Act, and UBOA dealt only in passing with insurance matters. Otherwise, there was discussion of very little else, and Chairman Danforth let it be known that our problem would have further attention from him and his Committee.

From day to day, we are awaiting announcement from the White House on how it will deal with the petition of the Small Business Legislative Council (SBLC, of which NTA is a member) for setting up a "Presidential Insurance Issue Task Force," which would be empowered "to examine the origins of the issue, and to propose a pattern of solutions."

The White House may be expected to seek a solution which will leave unimpaired state jurisdiction over matters regarding regulation of the insurance industry. Reflecting the Reagan Administration viewpoint was testimony before the Anderson Subcommittee that, "I've not seen evidence that there is need for federal action."

Whether before a Presidential task force or in any other forum, UBOA will continue to argue that our (SBLC) letter to the President was factual, and that "the insurance problem is complicated, enormously, by the fact that surveillance over the insurance industry's performance is basically the responsibility of the various states."

Whatever action may or may not be taken at the White House or on Capitol Hill, UBOA said to the Anderson Subcommittee that any legislative remedies should be directed toward:

1) establishing a federal presence on insurance regulation;

2) proscribing mid-term cancellations of coverage except for good cause;

3) determining what constitutes a reasonable limit on total awards for a single occurence; and

4) specifying that an insurors's total liability cannot extend beyond the limits of coverage for a particular occurence.

We described to the Subcommittee how UBOA knows bus owners "cannot be isolated, completely, from the real, outside world of insurance, its hazards, its pass-throughs."

UBOA conceded that bus owners themselves are obligated to pass through to their riderships the added costs of adequate insurance. We acknowledged that our successful petition to the Interstate Commerce Commission (ICC) gave us that exact tool, when the ICC authorized bus owners to add increased insurance costs to their rates and schedules, do-

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Bus Owners

Continued

ing so on just 10 days notice instead of 30 days.

The ICC has taken another very important step by issuing a "Notice of Investigation and Request for Comments" on insurance problems facing the motor carrier industry. In that undertaking, UBOA joined with the American Trucking Association to request the ICC to open an investigation, which ICC has approved, and which (in ICC's words) will "determine (1) the extent of the insurance crisis facing the motor carrier industry, (2) the causes of this crisis, and (3) what action, if any, is necessary to alleviate the problem...A carrier's certificate or permit remains in effect only if the carrier maintains appropriate insurance. The Commission is aware that carriers are experiencing increasing difficulty in obtaining the requisite insurance and that large increases in premiums are being charged to renew existing policies."

NTA members will be interested to know that the ICC expressly requests information on how the crisis is affecting female-owned enterprise.

Having acted both on UBOA's request for insurance-related rate increases and on the American Trucking Association's petition for an investigation, the ICC already has a good track record. ICC Chairman Reese H. Taylor polished that record a bit more brightly when, on October 30, he told the Anderson Subcommittee that reform in the bus industry is threatened by the insurance problem. He described how, prior to 1982, the ICC required each applicant to demonstrate public convenience and necessity before a permit could be issued. Now, he said, entry into the motor carrier industry is being regulated by the cost of insurance, and that insurance barriers are higher than any imposed by the ICC "even at its zenith."

Another extemporaneous statement by Chairman Taylor showed that he does not intend to play games with insurance, and that gypsies will not be allowed to continue to play games with the ICC. He said any commercial vehicle may expect to have its insurance certificate inspected whenever that vehicle is stopped for any purposes, such as weighing, roadside inspection, or traffic violation.

No certificate will be issued to anyone without proper evidence of insurance, and no certificate will be allowed to remain in effect unless it is backed by evidence of insurance. Recently, UBOA had a one-bus member grab a chance to sell the coach as the slow season began. The member wanted to keep the operating authority in place until spring, at which time another coach would be purchased or rented. The ICC would not agree to this. The problem was worked out when the carrier's insuror issued a policy on "named vehicles," and named none.

Chairman Taylor said there is a five-step process:

1) the insurance filing is entered into the ICC computer;

2) the insurance carrier notifies the ICC 30 days in advance that coverage is about to lapse;

3) 14-day letter-of-warning is sent to the motor carrier;

4) the motor carrier is given an opportunity to sign a "consent agreement" not to operate for 30 days or until replacement insurance is arranged;

5) insurance is revoked, and motor carrier is served with a court injunction, should operations be continued.

Motor carriers are advised not to "run bare" (without insurance, or with the barest minimum). The penalty is $10,000 for each day of violation.

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Bus Owners

Continued

The insurance industry has a point. The argument is that Congress should not legislate minimum liability coverage; that Congress cannot possibly tell what proper coverage might be; that if the ICC and the Department of Transportation are allowed to determine other standards to be met by certificated carriers, DOT should also be free to decide what liability coverage is needed.

Witnesses for the agencies have told Congress that they see the insurance problem not being complicated by the November 19, 1985, increase from $2.5 to $5 million for coaches with capacities greater than 15 passengers plus driver. On the other hand, the insurance industry argues that the increase to $5 million could not come at a worse time, and says it doesn't know if it's needed.

On another matter, UBOA agrees with the insurance industry in that we believe there must be a system to shine a light on the problem driver or the license violator. Both the insurance industry and UBOA are associate members of the Alliance for Motor Vehicle Administration Telecommunications (AMVAT). Already in place is funding for a "Request for Proposal." Would-be contractors will offer programs for setting up a computer-based network, whereby problem drivers and violators will be identified by their licenses, by their photograph (expressed in computer language), or by other means. DOT has estimated that as many as one-in-three commercial drivers may hold more than one driver's license. AMVAT will stop that practice.

But back to the matter of libel. Peter Gunn, speaking for the Independent Insurance Agents of America, told the Anderson Subcommittee, "Deregulation, high minimum limits of liability coverage along with the owners' and operators' lack of attention to safety have all played a part in the inability of insurance companies to risk their capacity by providing coverage."

Congress deregulates, then the insurance industry, as seen by Chairman Taylor, undertakes to re-regulate.

Minimum limits of coverage are too high; therefore, the insurance industry reduces coverage above the minimum, and charges more than was required for the higher coverage.

"Lack of attention to safety" is the greatest libel. No one anywhere has ever had a safety patrol such as that of UBOA. What's more, our safe buses have paid profits to insurance providers.

The facts are that our safe, profit-paying vehicles are being penalized along with those which are unsafe and unprofitable. Justice demands that we be treated according to our performance, not according to the records of the body of insured persons who are the true burden upon society. ©

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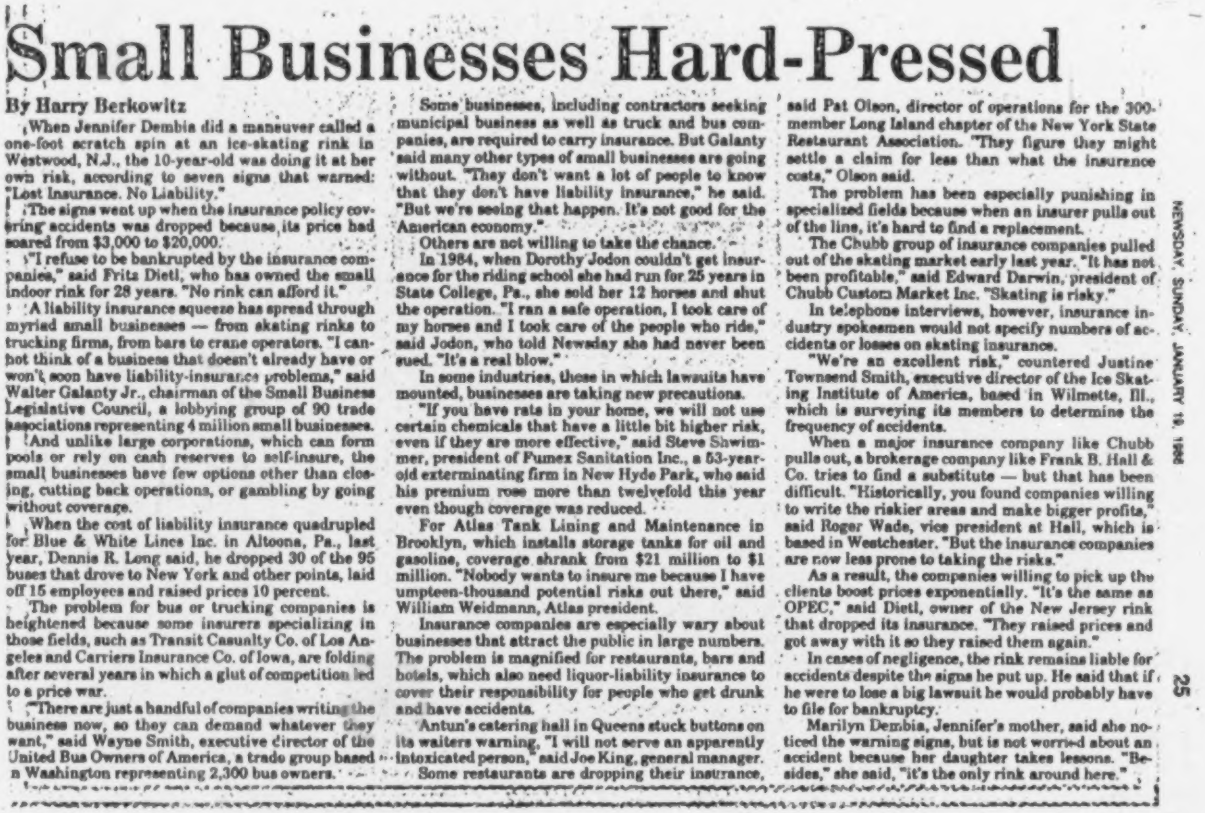

Small Businesses Hard-Pressed

By Harry Berkowitz

When Jennifer Dembia did a maneuver called a one-foot scratch spin at an ice-skating rink in Westwood, N.J., the 10-year-old was doing it at her own risk, according to seven signs that warned: "Lost Insurance. No Liability."

The signs went up when the insurance policy covering accidents was dropped because its price had soared from $3,000 to $20,000.

"I refuse to be bankrupted by the insurance companies," said Fritz Dietl, who has owned the small indoor rink for 28 years. "No rink can afford it."

A liability insurance squeeze has spread through myriad small businesses — from skating rinks to trucking firms, from bars to crane operators. "I cannot think of a business that doesn't already have or won't soon have liability-insurance problems," said Walter Galanty Jr., chairman of the Small Business Legislative Council, a lobbying group of 90 trade associations representing 4 million small businesses.

And unlike large corporations, which can form pools or rely on cash reserves to self-insure, the small businesses have few options other than closing, cutting back operations, or gambling by going without coverage.

When the cost of liability insurance quadrupled for Blue & White Lines Inc. in Altoona, Pa., last year, Dennis R. Long said, he dropped 30 of the 95 buses that drove to New York and other points, laid off 15 employees and raised prices 10 percent.

The problem for bus or trucking companies is heightened because some insurers specializing in those fields, such as Transit Casualty Co. of Los Angeles and Carriers Insurance Co. of Iowa, are folding after several years in which a glut of competition led to a price war.

"There are just a handful of companies writing the business now, so they can demand whatever they want," said Wayne Smith, executive director of the United Bus Owners of America, a trade group based in Washington representing 2,300 bus owners.

Some businesses, including contractors seeking municipal business as well as truck and bus companies, are required to carry insurance. But Galanty said many other types of small businesses are going without. "They don't want a lot of people to know that they don't have liability insurance," he said. "But we're seeing that happen. It's not good for the American economy."

Others are not willing to take the chance.

In 1984, when Dorothy Jodon couldn't get insurance for the riding school she had run for 25 years in State College, Pa., she sold her 12 horses and shut the operation. "I ran a safe operation, I took care of my horses and I took care of the people who ride," said Jodon, who told Newsday she had never been sued. "It's a real blow."

In some industries, those in which lawsuits have mounted, businesses are taking new precautions.

"If you have rats in your home, we will not use certain chemicals that have a little bit higher risk, even if they are more effective," said Steve Shwimmer, president of Fumex Sanitation Inc., a 53-year-old exterminating firm in New Hyde Park, who said his premium rose more than twelvefold this year even though coverage was reduced.

For Atlas Tank Lining and Maintenance in Brooklyn, which installs storage tanks for oil and gasoline, coverage shrank from $21 million to $1 million. "Nobody wants to insure me because I have umpteen-thousand potential risks out there," said William Weidmann, Atlas president.

Insurance companies are especially wary about businesses that attract the public in large numbers. The problem is magnified for restaurants, bars and hotels, which also need liquor-liability insurance to cover their responsibility for people who get drunk and have accidents.

Antun's catering hall in Queens stuck buttons on its waiters warning, "I will not serve an apparently intoxicated person," said Joe King, general manager.

Some restaurants are dropping their insurance, said Pat Olson, director of operations for the 300-member Long Island chapter of the New York State Restaurant Association. "They figure they might settle a claim for less than what the insurance costs," Olson said.

The problem has been especially punishing in specialized fields because when an insurer pulls out of the line, it's hard to find a replacement.

The Chubb group of insurance companies pulled out of the skating market early last year. "It has not been profitable," said Edward Darwin, president of Chubb Custom Market Inc. "Skating is risky."

In telephone interviews, however, insurance industry spokesmen would not specify numbers of accidents or losses on skating insurance.

"We're an excellent risk," countered Justine Townsend Smith, executive director of the Ice Skating Institute of America, based in Wilmette, Ill., which is surveying its members to determine the frequency of accidents.

When a major insurance company like Chubb pulls out, a brokerage company like Frank B. Hall & Co. tries to find a substitute — but that has been difficult. "Historically, you found companies willing to write the riskier areas and make bigger profits," said Roger Wade, vice president at Hall, which is based in Westchester. "But the insurance companies are now less prone to taking the risks."

As a result, the companies willing to pick up the clients boost prices exponentially. "It's the same as OPEC," said Dietl, owner of the New Jersey rink that dropped its insurance. "They raised prices and got away with it so they raised them again."

In cases of negligence, the rink remains liable for accidents despite the signs he put up. He said that if he were to lose a big lawsuit he would probably have to file for bankruptcy.

Marilyn Dembia, Jennifer's mother, said she noticed the warning signs, but is not worried about an accident because her daughter takes lessons. "Besides," she said, "it's the only rink around here."

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January 31st, 1986

Mr. John Satagaj
SBLC
Suite 1201
1025 Vermont Avenue, N.W.
Washington, D.C. 20005

Dear John:

The National Parking Association is a 35 year old Trade Association with over 1,100 members representing Operators, Owners and Builders of Parking Facilities.

The Liability Insurance Crisis is having a serious impact upon Americas Parking Industry. Last December our members were surveyed about the Insurance Crisis and nearly twenty-five percent responded.

Several respondees contend that the high cost of Insurance and their unability to obtain Liability Insurance Coverage at any price could force them out of business.

Our members are disgusted with the way the Nation's Insurance Companies have treated small firms. Although a Parking Company has experienced few or no insurace claims over the past three years, the Insurance Companies nevertheless, have generally tripled the rates or refused coverage.

Our members have been forced to scramble at the eleventh hour, with out warning, to try to find a carrier that would provide insurance coverage for their business at any price.

NPA's survey revealed that the cost of Workmans Compensation coverage has doubled through out the Industry.

Cost Garage/General Liability Insurance has generally tripled.

The cost of Garage Keepers Legal Liability Insurance has also tripled.

It is common for Umbrella Liability Insurance coverage for the parking industry in 1985 to cost from three to five times more than the 1985 premiums with sharpley reduced coverage.

An Umbrella Policy that took effect at $350,000 now takes effect at one million or two million and the top Umbrella Liability limit has generally been lowered from ten million to five million.

** Anthony V. Vena operates Fisch's Parking in Philadelphia, and his Company was forced to turn to the ASSIGNED RISK PROGRAM run by the state of Pennsylvania. He now pays a huge premium for a fraction of his 1984 coverage even though his firm has an outstanding loss experience record.

Mr. Vena says that his company is in danger of going out of business.

** The Parking Place in San Francisco has seen it's Cost Garage/Liability Insurance rise from $3.46 per stall to $10.00 per stall in one year.

** In January 1985, the Professional Parking Corporation in Nashville, Tennesse paid $1.50 per space for Cost Garage/Liability Insurance—Today it's premiums are $10.00 per space for reduced coverage.

** The Republic Parking System in Chatanooga, Tennesse paid $2,200 for five million dollars of Umbrella Coverage in 1984. In 1985, it could only get two million dollars of Umbrella Coverage which cost $38,000. Republic also saw it's Cost Garage/Liability Insurance skyrocket from $40,800 in 1984 to $143,000 in 1985. Despite a very favorable claims record.

** The Loop Parking Company in Minneapolis paid $6,000 in 1984 for a ten million dollar Umbrella Policy. There never was a claim under that coverage, but the Trasport Indemnity Company cancelled the coverage. Loop Parking in 1985 paid $30,000 for grossly reduced Umbrella Coverage.

Sincerely,

Tom Kobus

THOMAS G. KOBUS
Executive Vice President

Chairman PICKLE. Thank you, Mr. Satagaj.

The Chair would observe at this point that you concentrated in part of your testimony on the national scope of the problem.

The Chair meant to say, too, when Attorney General Bell was here, that I think it is the feeling of this committee that some kind of commission should be appointed.

We do have the President's working task force headed by Mr. Willard. One member of the committee, Mr. Schulze, has recommended a national commission. I notice you said in your testimony that you didn't think the administration presently was predisposed to set up such a commission.

I don't know if the Members of Congress want to go to a commission as the fallback on all these cases, but I do think that some kind of a broad-based forum should be set up to pursue this matter.

It is my feeling that we could at least ask the Speaker of the House in conjunction with the minority leader, Mr. Michel, to appoint a committee of members of the various committees with overlapping jurisdiction in this field. Representatives could be inserted from insurance companies and from various organizations affected by the crisis, as well as affected individuals.

I think that the recommendation we may make is that a committee be appointed to work as a national group. It is a national crisis, and we can't look the other way.

How we handle that is something I think the members would have to weigh. But I think that is our feeling at this point.

Do you share that, Mr. Schulze?

Mr. SCHULZE. Indeed, Mr. Chairman. You have succinctly stated my position.

Chairman PICKLE. I didn't want to interrupt the testimony, but I wanted to comment before we went further.

Now, Mr. Groves, we recognize you for 5 minutes.

STATEMENT OF RAY J. GROVES, CHAIRMAN, SPECIAL COMMITTEE ON ACCOUNTANTS' LEGAL LIABILITY, AMERICAN INSTITUTE OF CERTIFIED PUBLIC ACCOUNTANTS

Mr. GROVES. Thank you, Mr. Chairman.

I would like to offer my complete statement for the record, and then just summarize a few comments.

Chairman PICKLE. That would be fine.

Mr. GROVES. I am Ray Groves, representing the American Institute of C.P.A.'s. I am the immediate past chairman of the board.

The AICPA is the national professional organization of C.P.A.'s, and we have 240,000 members in public practice, industry, education, and government today.

There has been a dramatic increase in the past few years in the number and size of legal claims brought against accounting firms of all sizes. We believe this trend is to a large extent the product of the deep pocket syndrome.

Failures of business enterprises are usually accompanied by multimillion dollar suits against their independent auditors on behalf of shareholders and creditors. Indeed, the suits often focus on the C.P.A. firms because they are often the deepest pockets when a business fails.

It cannot be expected that liability costs, which are escalating, will be absorbed by insurance. The market for professional liability is increasingly unstable because of the inability to predict risk and potential losses.

Premiums are escalating, coverage is shrinking, and some carriers are refusing to offer such coverage altogether—the same you have heard from other people testifying, I am sure.

One example we have of the trend is the fact that underwriters from many State professional society programs have withdrawn from the market in the past few years and other programs are threatened with imminent demise.

Insurers withdrew, for example, from the New York State C.P.A. Society program which included over 1,500 accounting firms. Also, since 1984, aggregate premiums of the 11 largest accounting firms have multiplied a factor of 500 percent while the available coverage has been dramatically reduced to less than half.

Another example are the premiums paid and amount of coverage received by the 15,000 accounting firms whose staff sizes are up to 250 which are covered by the AICPA professional liability insurance plan.

In just the past 2 years, the limits of coverage available under that program fell from $20 million to $1 million or a drop of 95 percent.

Moreover, since accountants traditionally practice in partnership form each individual firm member faces personal liability for any partnership losses including judgments, settlements, or attorney fees in excess of the partnership assets. I believe this would be a major distinction between C.P.A.'s and other people who appear before you.

To deal with these issues, the AICPA suggests certain major areas of particular concern for reform.

One of the most significant reforms we would propose is replacement of the prevailing rule of joint and several liability with several liability alone. That is similar to Attorney General Bell's recommendation.

By replacing this rule with several liability alone, the defendant would not be compelled to pay more than his proportionate share of the claimant's loss relative to other responsible persons.

Another prime concern is deterrence of the increasing numbers of frivolous suits. This is a universal problem that affects not only accountants, but other professions, business entities, civic institutions, and governmental bodies.

The availability of contingent fee arrangements as well as the possibility of settlement by defendants unwilling to bear the high cost of defending actions creates incentives for the plaintiff's bar to file lawsuits against "deep-pocket" defendants regardless of merit. Therefore, we would favor proposals to establish either a maximum or some scale for contingency fees.

Finally, another major area of concern is the proliferation of RICO claims against accountants. This has become a grave problem for the profession in the wake of the 1985 U.S. Supreme Court decision in *Sedima* v. *Imrex*.

That case holds that legitimate businesses, including accounting firms, can be sued for treble damages plus court costs and attorney fees under the Federal RICO statute even though the suit is not based on any proof of racketeering.

Although the Supreme Court Justices unanimously agreed that civil RICO had come to be used in a manner not envisioned by Congress, a bare majority of the court held that whatever defect in the language of RICO leads to this misuse is, as the majority opinion put it, inherent in the statute as written and its correction must lie with Congress.

The AICPA supports existing proposals for corrective legislation.

In conclusion, the AICPA urges the subcommittee to add the particular professional liability concerns of accountants to the ongoing activity of the subcommittee in considering the liability insurance crisis.

Thank you for the opportunity to testify.

[The prepared statement follows:]

TESTIMONY OF

RAY J. GROVES

CHAIRMAN OF THE
AMERICAN INSTITUTE OF CERTIFIED PUBLIC ACCOUNTANTS
SPECIAL COMMITTEE ON
ACCOUNTANTS' LEGAL LIABILITY

INTRODUCTION

Mr. Chairman and Members of the Subcommittee: My name is Ray J. Groves. I am the Chairman of a Special Committee on Accountants' Legal Liability established by the American Institute of Certified Public Accountants (the "AICPA") and former Chairman of the AICPA Board of Directors. The AICPA is the national professional organization of certified public accountants (CPAs) in the United States. Its service to the profession and to the public spans almost one hundred years. Today, membership consists of over 240,000 CPAs in public practice, in industry, in education and in government. Over the years, the AICPA has been a principal force in developing accounting and auditing standards, educational programs, and issuing professional publications to improve the quality of services provided by CPAs.

I understand that the purpose of these hearings is to examine liability insurance -- its expanding costs,and shrinking availability to all segments of our society -- and to consider the impact of these conditions on various segments of the economy. I appreciate this opportunity to convey to this Subcommittee the particular perspective on these issues of the accounting profession, consisting of thousands of practice units serving the public, which range in size from a sole practitioner responding to the needs of his or her local community to large firms serving the needs of clients and the public throughout the world. As my comments will illustrate, in many respects the accounting profession shares the same liability and insurance problems experienced by other professional, trade and industry groups appearing before this Subcommittee. In other respects, the profession finds itself disproportionately burdened by ever expanding court imposed liability exposure at a time when adequate insurance is either too costly or too scarce to absorb the losses.

THE THREAT TO THE PROFESSION

The liability insurance crisis is a product, to a large extent, of the current liability climate and tort system. The trends that have increased the exposure of accountants to liability for alleged audit defects and contributed to the increasingly unstable insurance market pose a grave threat to the economic viability of the accounting profession. What is at stake is the ability of the profession to continue fully to serve the public's need for competent and objective financial reporting in the face of increasing liability exposure. What is at issue is the inability of the accounting profession and its insurers reasonably to predict for the forseeable future the standards to which courts will hold the profession in an increasingly expansionist judicial view of the profession's responsibilities.

There has been a dramatic increase in the past few years in the number and size of legal claims brought against accounting firms of all sizes. The awards sought in accounting malpractice cases and the anticipatory settlements they spawn have grown in tandem with the geometric growth of business transactions and financing.

This trend is to a large extent a product of the "deep pocket" syndrome. We live in a consumer oriented society. Our courts increasingly seem to be willing to abandon the concept of liability only when a "duty" to an injured person is breached in favor of a concept that every injury or harm must be redressed or compensated, regardless of duty to the injured person. Courts also look to those associated with the transactions or events to provide that recovery regardless of the degree or proportion of fault by individual defendants. Failures of large business enterprises usually are accompanied by multi-million dollar lawsuits against their independent auditors on behalf of shareholders and creditors. Indeed, the suits often focus on the CPA firms because they are usually the "deepest pockets" available in the financial rubble of a failed company.

Simply because a business has failed does not mean an audit failure has occurred. Often the financial statements of a failed company fairly reflect its precarious financial position. Further, even where the financial statements are found wanting, the party most responsible for the misstated financials is often not the auditor, but the client company or its senior management, sometimes aided by the collusion of third parties. In this scenario, however, the client company is financially insolvent and the responsible officers and directors probably do not have sufficient individual assets to meet the often astronomical damage claims. Too often the accountant, who usually practices with appropriate insurance coverage, is the only remaining solvent party. Thus, once a business failure occurs, there is an automatic tendency to name the auditor as a defendant, irrespective of whether there is any evidence to suggest the auditor was at fault.

Auditors practicing in partnership form, unlike corporate "deep pocket" defendants, find that their personal assets are at risk even if they have no direct contact within the firm for the particular engagement at issue. Thus, even where the auditor has been negligent the crushing burden of heaping the bulk of liability on him and on his partners, in the absence of other persons responsible has produced a crisis for the profession.

Moreover, the legal costs and expenses of defending suits, however baseless, accrue at an alarming rate and these factors may, in some instances, promote costly settlements. One indication of this trend is that the loss ratios under the AICPA liability insurance plan, which insures smaller accounting firms, have been greater than 100 percent. Also, according to a recent Business Week article, the eight largest firms have paid nearly $180 million in settlement of mostly audit related suits since 1980. As courts have recognized, the _in terrorem_ effect of the pendency of even the most meretricious litigation creates a settlement value in such lawsuits that may have no relationship to the quantitative size or qualitative merit of the claim. Also, in many instances, the issues are so complex and the stakes so high that it is extremely burdensome and risky for accountants to litigate through trial. When the potential for treble damages under federal and state RICO statutes is thrown into this equation the settlement imperative becomes even more compelling.

It cannot be expected that the escalating liability costs will be absorbed by insurance. The market for professional liability insurance is becoming increasingly unstable because of the inability to predict risk and potential losses: premiums are escalating, coverage is shrinking, and some carriers are refusing to offer such coverage altogether. One example of this trend is the fact that underwriters for many state CPA society professional liability insurance programs have withdrawn from the market in the past few years and other programs are threatened with imminent demise. Insurers withdrew, for example, from the New York State CPA Society program, which included over 1500 firms. Also, since 1984, aggregate premiums for the eleven largest accounting firms have multiplied by a factor of five, while the available coverage has been cut in half.

Another example is the premiums paid and the amount of coverage received by the 15,000 firms with staff sizes up to 250 covered by the AICPA Professional Liability Insurance Plan. In 1980, a firm with a staff size of 25 could obtain $1,000,000 worth of coverage with a $3,500 deductible per claim for a premium of $1,559 or about $64 per person. In 1986, the same amount of coverage but with a $7,000 deductible per claim would carry with it a premium of $28,725 or about $1,160 per person. Malpractice insurance rate increases for accounting firms of all sizes ranged from 200% to 400% for 1985.

THE PUBLIC INTEREST

What is needed is a realistic assessment of the policy implications of exposing auditors to potentially ruinous liability burdens. The need for accounting services has never been greater. The profession increasingly is being pressed to provide additional assurances as to financial statements, and to offer a broader range of services. Accounting services, and the audit in particular, are vital to the health of our national economy. It is unreasonable to expect that auditors can continue to provide needed services to the business and financial community, let alone increase the level and quality of those services, unless they can obtain greater certainty as to their exposure and relief from unreasonable liability.

The role of the independent auditor is not to guarantee the success of a particular business. Evaluation of the chance of success is the proper role of investors and creditors who will reap the rewards of their correct decisions and who should bear the risk of poor judgments in this respect.

The proper, long-standing role of the independent auditor is to provide the public with reasonable assurance that the representations of management reflected in the company's financial statements and related disclosures comply with generally accepted accounting principles. The independent audit should bring a trained, experienced, professional oversight to the financial reporting process and, thus, serve to deter the issuance of misleading financial statements by management.

In a January 1985 Pace University survey of Fortune 500 and private companies, 107 of the 117 respondents indicated that they would have an annual audit by a public accounting firm even if it were not required. The most frequently cited reasons were that the independent audit imposes discipline on the entire financial system and that an independent audit is required for the credibility of financial statements.

At present, proprietors and partners of accounting firms are finding it increasingly difficult to protect themselves against potentially ruinous losses. Audit fees, based on hourly rates, cannot be expected to keep up with escalating liability exposure.

Moreover, since accountants traditionally practice in partnership form, each individual firm member faces personal liability for any partnership losses (including judgments, settlements or attorneys' fees), in excess of the partnership's assets. This threat was recently dramatized by an audit malpractice case decided in Australia, Cambridge Credit Corporation Ltd. v. Hutcheson, where a judgment equivalent to U.S. $100 million was rendered against an accounting firm with about twenty-eight partners. The judgment far exceeds the assets of the partnership and the court has taken control of the personal assets of the individual partners to ensure that they are available to pay the judgment. Some U.S. firms of comparable size may soon find themselves in the same position in view of the fact that in the past two years the limits of coverage available under the AICPA professional liability insurance program fell from $20 million to $1 million, a drop of 95 percent.

Given the spectre of this magnitude of personal risk, there is serious concern that the accounting profession may not be able to attract or retain the most competent young people in the future, a development which must eventually affect the quality of service to business and the public. There is also room for concern that this risk will stimulate a variety of defensive tactics in the practice of accountancy. Accountants may decline a particular service or limit some aspect of the audit. They may be reluctant to accept new responsibilities or an expanded role in providing services to clients. They may engage in audit procedures, whose cost must be borne by the client, that have as their primary or sole purpose providing a defense in the event of subsequent litigation.

THE RESPONSE OF THE PROFESSION

Various initiatives are under way within the accounting profession to address these legal liability issues. The AICPA Special Committee on Accountants' Legal Liability is engaged in reviewing possible initiatives to reduce accountants' exposure to amounts and levels of liability consistent with their professional responsibilities. We have been coordinating our efforts with State Societies of CPAs across the country. We are also joining forces with coalitions of representatives from industry, trade and other professional groups, including the American Tort Reform Association, the National Coalition for Litigation Cost Containment and the Liability Crisis Working Group sponsored by the U.S. Chamber of Commerce. We are focusing on opportunities for tort reform at both the state and federal levels.

At the same time, the AICPA has mounted a significant effort to consider ways to improve and strengthen the standards and procedures governing the conduct of audits and other attestation engagements. This includes, among other things, current projects by the Auditing Standards Board to improve auditor communications as well as to provide additional guidance to auditors on their responsibilities for the detection of management irregularities or illegal acts. The AICPA was also instrumental in the establishment of the Treadway Commission, an interdisciplinary group meeting in Washington which is studying the root causes of fraudulent financial reporting.

TARGETED PROBLEM AREAS

Certain overriding trends have emerged out of our study of the legal liability experience of the accounting profession. First, the assumption that the accountant should be available to reimburse the losses suffered by unsuccessful investors too often proceeds without a fair analysis of the duty, if any, owed by the accountant to the party at loss, or an adequate examination of the shared responsibility of others for the loss. There is also an "expectation gap" in the public's understanding of the nature and function of an audit. There is a persistent misconception that a "clean opinion" on financial statements somehow guarantees a company's future success as well as the competence and integrity of its management.

This is not to suggest that accountants' liability for direct fraud is overexpansive; active and knowing wrongdoing by accountants should be judged by the established and stern standards that have already been applied. However, accountants' liability for negligence -- for unintentional mistakes and oversights -- should not be extended to the extent that accountants may face liability for indeterminate losses incurred by a potentially unlimited class of unknown users of financial statements. The same danger of overexpansive liability exists with respect to claims against auditors for indirectly aiding and abetting another person's fraud, where the auditor can be held liable to the same indeterminate class even though he had no actual knowledge of the underlying fraud.

To deal with these issues, the AICPA Special Committee has targeted certain major areas of particular concern for reform. While we have begun initiatives in certain areas, we are still at a preliminary planning stage and would hope to have an opportunity to report to the Subcommittee at some later time as our work progresses. At this time, we can provide a brief summary of the major initiatives under consideration.

1. Proportionate Liability

One of the most significant reforms we would propose is the replacement of the prevailing rule of "joint and several" liability with "several" liability alone, in federal or state actions predicated on negligence or aiding and abetting liability. Under the "joint and several" rule, a claimant can collect all or part of his damages from any defendant found liable, irrespective of that defendant's proportionate fault. For example, an auditor-defendant that is held to be only 5% responsible, may be required to pay 100% of the damages awarded and, in seeking contribution from other tortfeasors, bears the risk that they may be judgment proof. Although many states have adopted comparative negligence laws that provide for liability apportionment based on the parties' relative degrees of fault, all but a few states continue to maintain the rule of joint and several liability and an evaluation of comparative fault is meaningless if a minor tortfeasor must bear the cost of all damages. By replacing this rule with "several" liability alone, a defendant would not be compelled to pay more than his proportionate share of the claimant's loss relative to other responsible persons.

The joint and several liability rule lies at the heart of the "deep pocket" syndrome, which, as I have previously described, represents a threat to the very survival of the accounting profession. The rule is fundamentally unfair, in that it imposes disproportionate liability on whomever is the "deep pocket" defendant -- one who may have little actual responsibility for the loss and who may not be able to spread that cost to other tortfeasors.

The AICPA has encouraged the State CPA Societies to pursue legislative initiatives at the state level to replace "joint and several" liability with "several" liability. I would point out, in this respect, that many other groups, including state and local governmental units, are equally concerned about the issue of proportionate liability because they too have suffered considerably and unfairly as "deep pocket" defendants.

2. The Privity Rule

Another area of particular concern to the AICPA is a growing tendency to extend accountants' exposure to liability for negligence to an unlimited number of unknown third parties or non-clients with whom the accountant has no contractual or other relationship. In this respect, the AICPA endorses the rule, first enunciated over fifty years ago by Justice Cardozo, sitting on the New York Court of Appeals, in Ultramares v. Touche, 255 N.Y. 170 (1931), that only persons in privity -- or having a direct contractual relationship -- with an accountant could sue that accountant for negligence.

This rule continues to be followed in a majority of states and was recently reaffirmed by the New York Court of Appeals in Credit Alliance v. Arthur Andersen & Co. That case bars negligence suits against accountants by anyone except those in a relationship of privity or "so close as to approach that of privity," such as where the accountant knows and understands that the financial statements are intended for use by a particular party, for a particular purpose, and the accountant showed that he understood this through some direct contact with that particular party. However, some state courts, such as those in New Jersey, Wisconsin, and most recently, California, have recently abandoned or restricted the traditional rule. The AICPA is considering possible initiatives to encourage adherence to the privity rule in other jurisdictions, both through their courts and their legislatures.

The privity rule is based on a carefully drawn policy calculus. The auditor's duty to render an audit opinion with due care runs by contract only to the audit client. The auditor may anticipate that others -- such as investors and creditors -- might read and rely on the opinion, but typically has no ability to limit their numbers or to control or influence the magnitude of the risk they may take in reliance. While it may arguably be socially beneficial to compensate these third parties for their "innocent" reliance on an erroneous opinion, this benefit is vastly outweighed by the consequences of allowing a professional to be held liable for the negligent (as opposed to fraudulent) rendering of such an opinion to an unlimited number of unknown users of financial statements. As Judge Cardozo stated over fifty years ago in the Ultramares case:

> "If liability for negligence exists, a thoughtless slip or blunder, the failure to detect a theft or forgery beneath the cover of deceptive entries, may expose accountants to a liability in an indeterminate amount for an indeterminate time to an indeterminate class. The hazards of a business conducted on these terms are so extreme as to kindle doubt whether a flaw may not exist in the implication of a duty that exposes to these consequences."

255 N.Y. at 179-80.

Although the privity requirement was abandoned long ago in personal injury suits, there are good reasons to retain it in accounting malpractice cases. The liability exposure of auditors to investors and others injured by misleading financial statements stands on a different analytic footing from that of the product manufacturer or the doctor. The difference stems from the auditor's role of being a secondary, as opposed to a primary, participant in the circumstances giving rise to loss or injury. Unlike the manufacturer of a machine or appliance, the auditor does not have control over production or distribution of the defective article; that is the responsibility of the issuer of the financial statements. Unlike the doctor who wields a scalpel negligently or prescribes the wrong drug, the auditor, even if negligent, is often himself a victim of the primary wrongdoer's conduct; and, unlike the manufacturer, whose income or fees are directly related to the size of the transaction or the frequency of sales, the auditor's compensation is customarily based on the time devoted to rendering a service and does not reflect the size of the transaction or the growth of the client's business.

Accountants also face additional risks of secondary liability in their practice as partnerships. Each individual member of the partnership can be held personally liable for the obligations of the partnership that exceed the partnership's assets, and vicariously liable for the tortious acts of any partner, irrespective of whether that member bore any direct responsibility for the harm. Thus, whereas a doctor's negligence puts his own personal assets at risk, an accountant's liability passes to the firm and ultimately to the other partners as well. This is a burden that cries out for correction.

3. Frivolous Suits and Costs

Another prime concern is deterrence of the increasing numbers of frivolous lawsuits. This is a universal problem that affects not only accountants but also other professions, business entities, civic institutions and governmental bodies. The availability of contingent fee arrangements as well as the possibility of settlement by defendants unwilling to bear the high costs of defending actions creates incentives for the plaintiffs' bar to file lawsuits against "deep pocket" defendants, regardless of merit. The problem is intensified in the class action or derivative suit context. These suits cannot be settled without court approval of the settlement and the plaintiffs attorneys' fee award. This encourages plaintiffs' attorneys to generate unnecessary litigation activity to build up their time charges to justify a sizeable fee.

While the AICPA does not advocate the abolition of contingent fees, it objects to the abuses of the contingent fee system whereby lawyers may collect fees that bear no relationship to the time, effort, skill or value to the client of the legal services rendered. This system encourages attorneys to bring suits in which, although the probability of recovery is small, the recovery, if obtained, would be large. Furthermore, the named plaintiffs in many suits incur no risk because the costs of prosecuting the action are usually funded by the plaintiffs' attorneys. Even if the case is lost, the defendant is not normally entitled to recover his fees and costs from the plaintiff. The Chief Justice of the Supreme Court has spoken out against such misuse of contingent fees and stated that "The subject deserves careful study and the development of clear standards for the protection of the public."

The AICPA supports measures that would help to curb the abuses that have arisen under the current system. We would, for instance, support legislative proposals to impose costs or other sanctions on parties or their counsel who bring baseless suits or engage in dilatory practices. We would also favor proposals to establish maximum or reduced levels for contingency fees. Finally, the AICPA is investigating ways to resolve disputes between clients and accountants without resort to costly litigation in the courts, such as mediation or arbitration.

4. RICO

A final but major area of concern is the proliferation of RICO claims against accountants. This has become an especially grave problem for the profession in the wake of the 1985 U.S. Supreme Court decision in Sedima v. Imrex Co. That case holds that legitimate businesses, including accounting firms, can be sued for treble damages plus court costs and attorneys' fees under the federal RICO statute even though the suit is not based on any proof of "racketeering." In fact, such suits can be based solely on allegations of two or more instances of wire fraud (including interstate telephone calls), mail fraud, or fraud in the sale of securities, which take place over a ten-year period.

Although the Supreme Court justices unanimously agreed that civil RICO had come to be used in a manner not envisioned by Congress, a bare majority of the Court held that whatever defect in the language of RICO leads to this misuse is, as the majority opinion put it, "inherent in the statute as written, and its correction must lie with Congress."

Allegations of fraud can be easily framed in almost any business transaction gone awry. And this is exactly what has happened in the RICO arena. The statute is now being invoked in every kind of litigation where a disgruntled investor, purchaser, or business associate can possibly allege that another party to the transaction did not deal fairly with him.

According to comprehensive data recently collected on hundreds of civil RICO cases by the American Bar Association's Special RICO Task Force, 91% of all civil RICO cases rely primarily or solely on the securities, wire or mail fraud predicates of this organized crime statute. Only 9% of all civil RICO cases involve underlying allegations of criminal activity of the type generally associated with professional criminals. The statute has thus become primarily a tool for civil litigants to avoid the carefully crafted limitations of the federal securities laws and to federalize a wide variety of local commercial disputes.

In his testimony before this Committee in May 1985, addressing the need for civil reform, Assistant Attorney General Trott of the Department of Justice reported that the Department's own survey of private RICO cases confirmed this pattern of massive abuse. He estimated that, as a result of the increasing use of civil RICO in commercial disputes, the actual number of private cases filed already exceeds 500. According to the Justice Department's calculations, only about 7% of these cases involve either actual organized crime figures or the kinds of criminal conduct common to organized crime syndicates.

There are at least twenty-two RICO suits now pending against small CPAs insured under the AICPA liability insurance plan and at least an additional thirty-one are pending against larger firms. The number of suits and the costs to defendants can be expected to worsen considerably unless RICO is amended because treble damages will raise the stakes causing higher settlements and verdicts.

The AICPA has been active in mobilizing support for corrective legislation. One bill introduced by Representative Rick Boucher last year provides that civil RICO actions can only be initiated against businesses and individuals who have been convicted of certain criminal violations. Such a bill would confine the situations in which suits can be filed to those in which public prosecutors have screened those people who may fairly be charged with being involved in real criminal activity from those who should not be subject to accusations of "racketeering." I emphasize that, if Congress enacts this kind of amendment, persons allegedly injured by conduct that has not led to criminal prosecution and conviction would still have available all the other federal and state law remedies that apply to commercial disputes and alleged torts. The prior-criminal conviction requirement would be the most direct and precise way to return RICO to its intended use as a weapon against career criminals, and its abuse as a weapon in ordinary commercial litigation would end.

CONCLUSION

To summarize, the growth of the economy and increase in the size of financial transactions have increased the burden of potential liability for accountants and contributed to the current liability insurance crisis. Billion dollar losses by investors are not beyond contemplation, yet auditors' fees can not be expected to grow commensurately, and the ability of auditors to respond to massive damage claims could threaten the viability of the profession and reduce the quality and scope of services that the profession can provide. Society will not benefit if this should occur and auditors should not be regarded as insurers of a company's financial health or as predictors of its results.

The AICPA urges this Subcommittee to focus its attention on the liability burdens facing accountants, as well as other professional, trade and industry groups, in this broader societal context. We hope that you will add the particular professional liability concerns of accountants to the ongoing activities of the Subcommittee in considering the liability insurance crisis and that you will be receptive to recommendations that we may make at an appropriate time.

Thank you for the opportunity to testify. I would be pleased to respond to any questions.

Chairman PICKLE. I thank you, Mr. Groves.

I want to say to you and to the other panelists that your entire statements will be included in the record.

Thank you for your summary.

Now, Mr. Dalton.

STATEMENT OF DAVID W. DALTON, PRESIDENT, REAL ESTATE SECURITIES & SYNDICATION INSTITUTE, ON BEHALF OF THE NATIONAL ASSOCIATION OF REALTORS

Mr. DALTON. Thank you, Mr. Chairman and members of the committee.

I am David Dalton from Desoto, TX. I want to thank you for the opportunity to comment on the significant impact which escalating cost and limited availability of liability insurance are having on the real estate industry and the substantial rent increases that these escalating costs mean for both residential and commercial tenants.

In approaching the insurance marketplace, real estate firms are finding fewer carriers that are willing to quote premiums. Especially with respect to frame apartment buildings, most carriers are simply unwilling to offer coverage no matter how well those apartments are managed, or how good the loss experience has been.

Such restrictions have placed the real estate industry in a precarious position. Under the threat of having no coverage at all, we have often had to contend with a kind of "take it or leave it" attitude by those carriers willing to consider insuring us.

In the syndication segment of the industry alone, we have seen primary liability pricing for limits up to $1 million more than doubling. One company recently reported a 500-percent increase. Securing liability limits beyond that point has proven even more difficult. Increases in excess liability insurance have averaged 400 percent, although in specific instances that increase has been even higher. One real estate investment firm recently paid over $1 million in premium or $10 million in excess limits versus the previous year's premium of approximately $250,000 for $100 million in coverage. While in the last 4 months this firm has been attempting to secure at least $10 million more in limits, it has been unable to find an insurer that is even willing to quote. In another example, a firm paid $42,000 last year for $10 million. This year the price was $920,000 for the same amount of coverage.

Another example is the Hamlet Apartments in Clarksville, IN, whose premium for fire and extended coverage rose from $27,000 in 1985 to $41,000 in 1986.

Before leaving the office this morning, I was told by our accountants that our premium has more than doubled from $9,000 to $19,000.

Linden, Inc., is a construction and roofing company located in Chicago. The premium for its 1985 liability policy, including a $1 million umbrella, was $8,106. The premium on Linden's 1986 liability policy, without the umbrella coverage, was $15,202. Thus far it has been impossible to replace the umbrella coverage, but it is estimated that it will cost $5,000 to $8,000. Thus, the total premiums, if coverage is found, will have gone from $8,106 to at least $20,202, and probably more, in 1 year. Without the umbrella coverage, this small company cannot bid on major construction or roofing work. Therefore, its liability policy, like those of all small businesses, is vital to its ability to compete.

Commercial tenants, both large and small, are not immune from the crisis either. In some cases, they cannot secure coverage or the costs of insurance are so prohibitive that they are finding it difficult to even pay the rent. This has forced some tenants to consider going out of business. While property owners seek to be as flexible as possible with respect to the insurance required of such tenants, they also find it presents them with another dilemma. How do you keep tenants while at the same time exposing real estate managers, or the investors they represents, to as little uninsured risk as possible? Or, in other words, if no or limited coverage is available, what protection is afforded to not only the property owner and tenant but also to the legitimate claimant who suffers injuries?

Faced with an explosive increase in premiums and substantially reduced coverage, prospective real estate investors, developers, and lenders are having to reevaluate their participation in new projects. Obviously, the ultimate result of their reluctance to develop and invest in real estate will be a decreased supply of rental housing, driving up rents. Less commercial space will be developed, making it more difficult for small retail and service businesses of all kinds to find space or renew leases at affordable prices. Faced with both rising rents and their own insurance crisis, they will be forced out of business. Further, it will become less economic to rehabilitate older buildings, thus slowing the renewal of the central cores of our older cities.

The adverse effect of these developments on employment is incalculable. Job losses in construction and real estate will spread throughout the economy, starting with manufacturers and distributors of building supplies.

Millions of Americans are homeowners, and millions more aspire to be. The premium for the average homeowner's liability coverage has increased by 30 percent in just 1 year. Further increases of this magnitude will contribute to the well-known problem of affordability of homes. Not only is the property liability insurance becoming expensive or unobtainable, but so is liability insurance for the officers and directors of real estate firms of all types. This has a severe dampening effect on the willingness of qualified individuals to serve in these key roles. Lack of insurance or unaffordable insurance will have a dampening effect on our entire industry. It is damp out here already, and it just keeps getting wetter.

Thank you.

[The prepared statement follows:]

STATEMENT OF DAVID W. DALTON, NATIONAL ASSOCIATION OF REALTORS

I am David W. Dalton, President of the REAL ESTATE SECURITIES AND SYNDICATION INSTITUTE® (RESSI®), an affiliate of the 712,000 member NATIONAL ASSOCIATION OF REALTORS® which is an organization representing members in all 50 states, the District of Columbia, and Puerto Rico. Its members are actively engaged in the sale, brokerage, management, counseling and appraisal of residential, commercial, industrial, recreational, and agricultural real estate. The activities of these members involve all aspects of the real estate industry, ranging from mortgage banking and home building commercial to residential real estate development.

RESSI® membership represents individuals who specialize in the creation, issuance, analysis, and management of real estate securities. The syndications with which our members are involved range from relatively small private placements of developed and nondeveloped land to multi-million dollar syndications of large real estate complexes.

In approaching the insurance marketplace, real estate firms are finding that fewer carriers are willing to quote premiums. Especially with respect to frame apartment buildings, most carriers are simply unwilling to offer coverage, no matter how well those apartments are managed, or how good the loss experience has been.

Such restrictions have placed the real estate industry in a precarious position. Under the threat of having no coverage at all, we have often had to contend with a kind of "take it or leave it" attitude by those carriers willing to consider insuring us. Often premium quotes arrive 24 hours before insurance policy expiration, affording little opportunity to negotiate, and forcing us to accept terms and conditions which increase the exposure to loss.

In the syndication segment of the industry alone, we have seen primary liability pricing for limits up to $1 million more than doubling. One company recently reported a 500% increase! Securing liability limits beyond that point has proven even more difficult. At substantially reduced limits, increases in excess liability insurance have averaged 400%, although in specific instances that increase has been even higher. One real estate investment firm recently paid over $1 million in premium or $10 million in excess limits versus the previous year's premium of approximately $250,000 for $100 million. While in the last four months this firm has been attempting to secure at least $10 million more in limits, it has been unable to find an insurer that is even willing to quote. In another example, a firm paid $42,000 last year for $10 million. This year that price was $920,000 for the same amount of coverage.

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- Faced with an explosive increase in premiums and substantially reduced coverage, prospective real estate investors, developers and lenders are having to reevaluate their participation in new projects. Obviously, the ultimate result of their reluctance to develop and invest in real estate will be a decreased supply of rental housing, driving up rents. In addition, less commercial space will be developed, making it more difficult for small retail and service businesses of all kinds to find space or renew leases at affordable prices. Over time, smaller and financially weaker establishments, faced with both rising rents and their own insurance crisis, will be forced out of business. Further, it will become less economic to rehabilitate older buildings, thus slowing the renewal of the central cores of our older cities.

The adverse effect of these developments on employment is incalculable. Job losses in construction and real estate will spread throughout the economy, starting with manufacturers and distributors of building supplies.

Millions of Americans are homeowners, and millions more aspire to be. The premium for the average homeowner's liability coverage has increased by 30% in just one year. Further increases of this magnitude will contribute to the well-known problem of affordability of homes.

Not only is property liability insurance becoming expensive or unobtainable, but so is liability insurance for the officers and directors of real estate development, investment, brokerage and management companies, the general partners of real estate limited partnerships and the trustees of real estate investment trusts (REITS). This has a severe dampening effect on the willingness of qualified individuals (including outside directors and independent trustees) to serve in these key roles. Again, if this situation continues over a period of time, the effect will be less construction and rehabilitation of real estate and higher rents for both residential and commercial tenants. Futher, real estate limited partnerships and real estate envestment trusts serve the vital role of capital formation in our economy, aggregating the savings of hundreds of thousands of small investors and the contributions of an equal number of individual retirement accounts (IRAs) for investment in real estate projects. Lack of insurance, or unaffordable insurance, will have a dampening effect on capital formation for developing, investing in or lending to real estate projects.

I appreciate the opportunity afforded me by the Subcommittee on Oversight to comment on this most important issue and will be pleased to provide any further elaboration you may require.

Chairman PICKLE. I thank you, Mr. Dalton.

I thank the entire panel.

Let me first engage my mayor in some colloquy here.

As I understand it, Mayor, you said that the city of Austin has a self-retention limit of $5 million?

Mr. COOKSEY. Yes.

Chairman PICKLE. Does that mean that your city guarantees protection or coverage up to that amount and that you pay for that yourself as a city, and that you do not have insurance liability above that amount?

Mr. COOKSEY. Well, we do pay for anything up to that amount, and up until last year we had some coverage that covered us above that amount but since the cost of it became so phenomenally high for that area, $1.2 million, we just decided to go it on our own.

Chairman PICKLE. Are you, by saying you "go it alone," in effect saying that you are "going bare" above that amount?

Mr. COOKSEY. We are self-insured.

Chairman PICKLE. You are self-insured above the $5 million level?

Mr. COOKSEY. That is right.

Chairman PICKLE. Is that typical of cities throughout the United States?

Mr. COOKSEY. I think all the cities in the United States are facing similar problems. And at the recent Conference of the National League of Cities here in Washington, I went on the committee for finance and administration that considered a number of issues and this was one of the issues that we focused upon as being one of the two or three top priorities for the National League of Cities this year.

Chairman PICKLE. Could you give me an estimate on what the level of increase of insurance for the city of Austin has been?

I know you have your $5 million self-limitation and you have some insurance above that.

Has your insurance gone up 100, 200, 500 percent? What is the median level of increase that you can probably estimate?

Mr. COOKSEY. Well, it depends on the coverage you are talking about, Congressman. Our airport coverage increased in 1 year sevenfold. Our property insurance doubled. So it depends on the particular kind of insurance you are talking about, and then of course some kinds of insurance have just become unavailable.

One of the real problems in our insurance is insurance for our park system, for example. I know that our park director, Charles Jordan, who is on the President's Commission for the Out of Doors, is mentioning that this is one of the problems facing the cities and States who run park systems.

Chairman PICKLE. Your insurance has increased anywhere from 100 to 700 percent.

Mr. COOKSEY. That is right.

Chairman PICKLE. This is true even though you have one of the best insurance records in the country. You are leaders in liability prevention and you haven't had any damages over $1.2 million.

Mr. COOKSEY. That is correct.

Chairman PICKLE. There has been no fault found with your city or region, yet your insurance has gone up.

Mr. Cooksey. That is right.

Chairman Pickle. So you are having to pay costs that are six and seven times higher than previously increased.

Mr. Cooksey. That is right.

Chairman Pickle. Is that typical of most cities throughout the country?

Mr. Cooksey. I think it is. The stories I have heard at the National League of Cities meeting indicate this problem is being experienced all over the country.

Chairman Pickle. I noticed you recommended that in our State, at least, that among other steps that can be taken, the Texas Tort Claims Act would be amended to extend governmental immunity to our proprietary functions.

Mr. Cooksey. Right.

Chairman Pickle. In Austin, there is a law that says you are protected under the Tort Claims Act regarding hospital injuries.

Mr. Cooksey. For governmental functions.

Chairman Pickle. And you have a limitation of $400,000?

Mr. Cooksey. $400,000; yes, $100,000 per person, $300,000 per occurrence.

Chairman Pickle. Your States have gone up almost as if there was no such law?

Mr. Cooksey. That is right.

Chairman Pickle. How could an insurance company claim increased liability when there is protection under a law that has a cap already?

Mr. Cooksey. Our experience indicates as was indicated here, that people in the insurance industry are not looking at the specific situations of individuals who are seeking coverage, either toward—they don't look toward claims experience of that company or institution, or they don't look at specific State laws that would have a dramatic effect on the liability, possible liability.

Chairman Pickle. Well, I thank you very much.

It would seem to me, then, that the average city in the United States is almost being held captive and the only protection they have is either through self-insurance, having to fall back on their internal funding, or else rely on their taxing authority, one of the two. Those are the only alternatives they have.

Mr. Cooksey. That is right. I have recommended in this current budget year that we point out specifically to the citizens of Austin those expenditures that we are having to make and set aside funds for self-insurance, so they understand why their taxes are being raised.

Chairman Pickle. Have you made such a statement, pronouncement to your city?

Mr. Cooksey. We are going to do that in the upcoming budget year.

Chairman Pickle. Well, I thank you.

I have a question or two for the other panelists, but I would yield to Mr. Anthony.

Mr. Anthony. Thank you, Mr. Chairman.

I would just like to follow up on some details of your statement. The $1.2 million settlement, that was an actual settlement made to a claim being made against the city?

Mr. COOKSEY. Yes; it was.

Mr. ANTHONY. Was it before the year 1981?

Mr. COOKSEY. Well, I——

Mr. ANTHONY. You have numbers for 1981, 1982, 1983, and 1984.

Mr. COOKSEY. No; I don't think it was before 1981. I think it was after the year 1981.

Mr. ANTHONY. If you would, turn to the city of Austin liability claims experience. You have years 1981 through 1984.

Mr. COOKSEY. Yes.

Mr. ANTHONY. You show the number of claims and the amount of money. You have done quick figuring here, a little over $770 in 1981 jumps up to $1,500 in 1982, drops back to $900 in 1983, and about $1,400 in 1984.

Mr. COOKSEY. Yes.

Mr. ANTHONY. That $1.2 million is not reflected in those numbers.

Mr. COOKSEY. No; I think it is a recent settlement.

Mr. ANTHONY. Recent?

Mr. COOKSEY. Yes.

Mr. ANTHONY. The only point I want to make is that the average settlement there I think might surprise a lot of people.

Mr. COOKSEY. Yes.

Mr. ANTHONY. You are looking at a 4-year experience and the average claim is quite small, when you have people coming in here talking about the shocking runaway, out of synch tort system, you are punished because your experience has not been that high and you can't get the availability of insurance.

Mr. COOKSEY. That is right.

Mr. ANTHONY. I think that is a valuable addition to this record. When you go to the Small Business Legislative Council you look at some of the data that you have added to your testimony. It is also very shocking. For the people in the insurance business, I think they ought to be aware of this number.

In your liability insurance data from the Automotive Service Council's members, January 1986, from 143 members that were surveyed here was a question, owner happy with insurance carrier and reports no premium increase or cancellation, only 2.8 percent. I think that says it all there.

I think what is also very disturbing is not only the number of premium increases, but the amount of premium increases. Also, the large number of policies that were canceled. I assume many were canceled midterm.

On the Automotive Service Council, I assume you are familiar with them?

Mr. SATAGAJ. Yes.

Mr. ANTHONY. What type of insurance coverage is it? What type group is that? Is that regular automobile?

Mr. SATAGAJ. These are independent garages.

Mr. ANTHONY. Yes.

Mr. SATAGAJ. They do repair work. They do the repair work.

Mr. ANTHONY. Oh, they do repair. That is even worse. I assume that their exposure and their liability would have to be—their experience, I assume, has been fairly low. Are you familiar with it?

Mr. SATAGAJ. I am not that familiar with their experience, but I have been told it is low. There is no statistical data on that question here.

Mr. ANTHONY. When you look at your testimony and the data attached, it sure makes a strong case for cross-subsidization within the insurance industry for other lines of insurance. This has been very costly as far as loss ratio over premiums collected, because you have really demonstrated a great deal of data where the premiums have greatly exceeded the experience loss ratio.

Mr. SATAGAJ. Yes.

Mr. ANTHONY. We asked this question of some of the industry people. They all denied that there is any cross-subsidization going on, but this data certainly begins to shed some light on that question.

We will just keep looking at it and keep studying. But I thank you for your testimony.

I yield the balance of my time, Mr. Chairman.

Chairman PICKLE. Mr. Schulze.

Mr. SCHULZE. Thank you, Mr. Chairman.

I thank the panel members for their very interesting testimony.

Mayor, do you have a municipal transit authority?

Mr. COOKSEY. We were operating a transit system, but recently we created a transit authority in our area; Capital Metro, which is a separate governmental entity.

Mr. SCHULZE. Have they been hit with any large claims?

Mr. COOKSEY. I don't know their claims experience. They have only been in operation for a little over a year.

Mr. SCHULZE. The reason I ask that, Mayor, is I was visiting with some transit people a week or so ago, and I was told the story about a bus which discharged a passenger. As he left the bus, he was hit by a drunk driver who had gone through a stop sign. The municipal bus authority ended up paying $11 million and having their insurance canceled.

That is part of the deep-pocket syndrome. That is where the money was.

It seems to me that the legal structure is going where the money is and causing the problems, and let me also say, were I an insurance company and I saw this potential, if it happened in one municipality, I would have to say it hasn't happened in Austin but I won't be hit between the eyes if it does.

The insurer was Lloyds of London in this case. They canceled out and walked away. I don't think you can necessarily take premiums from life or some other area, and have it pay your casualty claims.

I know that trial lawyers have a feeling they can just milk insurance companies and nobody pays. But it seems to me the people are paying for it and the people are suffering because of these high premiums. It has to stop.

For the other panelists, is there a relationship between premiums paid and insurance payouts in your opinion?

Mr. GROVES. Yes. Yes; I think the increases in premiums are because there have been more claims paid. I know we have paid more losses.

Mr. SCHULZE. Do you think——

Mr. GROVES. Whether or not it is the right ratio, I don't think we are capable of determining that.

Mr. SCHULZE. Do you have any thoughts on how we can get them, as the chairman says, to sit around a table and talk about the current crisis in liability insurance? That would be a start.

If you had a magic wand, which of the things would be the most—two or three most important things you would do to solve this crisis?

Mr. Dalton.

Mr. DALTON. I think I would point to what is going on now and that is the need to focus attention on the matter. The fact is, as you observe, there is no single culprit here.

The only way we will be able to accomplish concessions, compromise, adjustment, and some changes among all participants—I would rank myself as an insurance person as probably eligible for some sort of suggestion of some change in my behavior that could take place. Until we accomplish that broad-base change and compromise, we are not going to have a solution.

Accordingly, I think the key is to focus increased attention on the problem and certainly that is one thing the insurance companies have accomplished by raising the rates dramatically.

Mr. SCHULZE. Mr. Groves.

Mr. GROVES. I think the joint and several recommendation by Attorney General Bell is one of the factors that would bring reasonableness and equity into the situation.

I think my colleague on my left said we need some balance in the system. It just tilted too much one way.

There has to be compensation for damages and losses. The question is what is a reasonable amount and what is fair?

I think joint and several is one. I think changes in RICO would be a second one. Not doing away with contingent fees but having a reasonableness or scale, as the chairman said, by people involved sitting down together.

I don't have a particular answer to that one. But I thought the Attorney General had a very reasonable suggestion.

Mr. SCHULZE. Nearly everybody except the trial lawyers agree to that.

Mr. Satagaj.

Mr. SATAGAJ. We would reform the civil justice system; we would talk about joint and several liability and a contraction of strict liability coupled at the same time with some minimum standards on insurance regulation, Federal activity, or a minimum standard.

A lot of the insurance problem is data collection. We feel more of the problem is getting data on the insurance companies, rather than a specific regulation. We would couple the two.

Mr. SCHULZE. Mr. Cooksey.

Mr. COOKSEY. I, of course, am a lawyer and am very sympathetic with the needs of the plaintiffs bar to be able to represent people who have really been hurt and deserve to have protection.

However, I think the joint and several suggestions that have been made by Attorney General Bell may well be a proper step forward.

Another thing that I think we might want to consider is a method used in the area of divorce law where we have come more and more to rely on arbitration and resolution of differences by a master.

One thought that occurred to me in this area is that perhaps we might get to a system where the jury does establish whether liability is present, but allow a master to establish the damages and in doing so, also perhaps have a national system of something similar to actuarial computations of damages so there is some evenness in the system of what damages are awarded.

Mr. SCHULZE. Would you have the master set the compensation for the attorneys, also?

Mr. COOKSEY. Well, I think that that might be possible. I don't know whether that would be a good idea or not.

The attorneys fees, as you know, are usually established either by a contingent fee arrangement, which I agree probably does need modification.

Mr. SCHULZE. The fact that two-thirds of that money is going to the lawyers, shows there is something wrong with the system.

Mr. COOKSEY. If that is really correct, that is certainly a gross injustice to those who are supposed to be receiving the compensation for their injuries.

But I don't know whether that is in fact the correct assessment. I would be surprised if it was.

Mr. SCHULZE. Not only Judge Bell said that, others have testified to that figure.

Mr. COOKSEY. If that is in fact the case, then that is skewed toward the attorneys and should not be.

Mr. SCHULZE. Greed is the word for it.

Mr. COOKSEY. Yes.

Mr. SCHULZE. Thank you.

Chairman PICKLE. Mr. Groves, I notice that you stated in your testimony that you hoped this committee would be receptive to recommendations you may make at the appropriate time. Is your group going to give us specific recommendations from the C.P.A.'s?

Mr. GROVES. Yes, Mr. Chairman. We are working in committee and with the counsel for the AICPA to put some, in effect, more meat on some of these suggestions we have made in our paper, but also to see if there are other suggestions we can offer to bring a better balance into play.

Chairman PICKLE. Mr. Dalton, you pointed out the exorbitant high cost of insurance in the area of realtor operations, both for the individual tenant and commercial firms.

I am asking you, are you or your group, going to submit to us some specific recommendations you think we should follow?

Mr. DALTON. Yes, sir; we just appointed task forces with respect to that to take it up.

Chairman PICKLE. I assume, Mr. Satagaj, particularly since you started out with public hearings and insurance wasn't one of the items discussed and now it is the No. 1 item, that you would have recommendations.

Mr. SATAGAJ. Yes.

Chairman PICKLE. We would like to know not only how it is affecting your industry, because it is devastating, but we would like to have your suggestions.

Mr. SATAGAJ. Yes.

Chairman PICKLE. I would ask the panel as a whole, if we were to ask that an ad hoc committee on insurance liability be appointed by the House of Representatives, including some professional groups outside the House, would that be a step in the right direction?

Mr. SATAGAJ. Mr. Chairman, I think it would. Our only requirement would be that it be given us specific mandates to do something in a period of time.

The only thing we fear is we will set up a commission and do nothing but study. We want to be sure it gets to action. We very much support that.

Chairman PICKLE. You are justified in making that observation, too.

Do the members have any other questions? If not, I want to thank you.

Thank you very much.

Mr. ANTHONY [presiding]. The next panel consists of C. Rollins Hanlon, Merwyn Bagan, Robey Thompson, Harry Jonas, and Ruth Watson Lubic.

Your entire statements will be accepted for the record, and you are recognized to proceed as you choose.

We will start with Dr. Hanlon, director, American College of Surgeons.

STATEMENT OF C. ROLLINS HANLON, M.D., F.A.C.S., DIRECTOR, AMERICAN COLLEGE OF SURGEONS

Dr. HANLON. Mr. Anthony, members of the subcommittee, I am Rollins Hanlon, director and fellow of the American College of Surgeons, on whose behalf I appear before you. The college is appreciative of this opportunity to share the views of its members about the professional liability question.

The college, Mr. Anthony, is a voluntary and scientific educational organization devoted to ethical and competent practice of surgery and to provision of high-quality care for the surgical patient. It provides extensive educational programs for its 48,000 fellows and for other surgeons in the United States and throughout the world.

It also cooperates in the education of nurses and allied health care practitioners. In addition, it establishes standards of practice, disseminates medical knowledge, and provides information to the general public.

In 1918, the college established the Nation's first voluntary hospital standardization program, designed to improve the level of patient care in hospitals. It supported this program with its own funds for 35 years. Out of this effort came the Joint Commission on Accreditation of Hospitals, or JCAH, the Nation's principal hospital survey and accreditation body of which the college is a member. We have recently pioneered in the development of books and programs designed to improve the level of patient safety in hospitals. We have distributed in the past several years some 5,000 of these books to hospitals in an effort to assure a safer environment for the patient being treated in hospital. This initiative was designed to lessen the risks that inevitably accompany sophisticated treatment in today's high-technology hospitals.

To achieve the goal of excellence in the provision of quality surgical services for patients, the college also maintains strong bonds with physicians in the various surgical specialties through representation on its board of governors, as well as through some 11 surgical specialty advisory councils. We will list specifics on this elsewhere.

Such efforts on behalf of the patient go back to the 1918 standardization program noted earlier. They are reflected as well in the thousands of surgeon members of the college who serve on local trauma committees designed to improve the care of the injured at every level from roadside to the hospital emergency room and operating room. There are other fundamental programs in the college such as those devoted to safety in the workplace, a national effort commended by the Nation's union leaders as long ago as 1920.

Mr. Anthony, I cite these programs and concerns of the American College of Surgeons, to indicate our organization's devotion for 73 years to the better care of the surgical patient. That care extends to a concern that the sick or injured patient should be skillfully and safely brought back to a healthy condition, and if care of the patient results in a status of severe disability, that every effort be made to assist the patient or the worker in coping with that disability, including adequate compensation.

This is the purpose of compensation systems—to assist and to compensate the patient fairly and promptly for misadventures suffered in the course of treatment. The American College of Surgeons is firmly convinced that the current system of professional liability insurance fails to accomplish that basic purpose centered on the patient, in addition to the intolerable burdens that it places on physicians, surgeons, and other persons and institutions engaged in patient care.

When I say that it is intolerable, I am not speaking merely of heavy financial burdens that occupy a rising percentage of the total expenses for physicians in practice. It is not only the change in patterns of care by surgeons and others who have been forced to abandon certain high-risk operations and other treatments because they simply cannot sustain the danger of a lawsuit that is likely to result from such treatment methods. Nor do I refer to the personal tragedy of practitioners in surgery and obstetrics, for example, who are retiring prematurely in increasing numbers because the financial and psychological stress of practice under the growing threat of litigation has made it impossible for them to continue.

Setting aside the personal tragedy of these physicians driven from practice to look at the patients who are thereby deprived of treatment by individuals at the peak of their capacity to care for the sick and injured, we see the real dimensions of the disaster that has overtaken our health care systems as a result of the professional liability. Access to care is being restricted by rising costs, by unavailability of certain medical and surgical treatments and by the departure of skilled physicians and surgeons from the field of practice.

Despite these obvious manifestations of the crisis, we see statements from the plaintiff's lawyers that there is no problem with the system, and that if any problems exists it lies at the door of incompetent physicians and hidden profits in the insurance industry. Both of these assertions, in my opinion, are transparently false; the trial lawyers and their material that attempts to support these claims contains gross misrepresentation.

These misrepresentations are plainly and convincingly refuted in the August 1985 response of the American Medical Association to statements by the Association of Trial Lawyers of America regarding the professional liability crisis. A review of that document should convince any neutral reader that the statement by the trial lawyers: "* * * there is no medical malpractice insurance crisis," is clearly contradicted by the AMA rebuttal.

The situation is complex. The solutions are not easy, and the statement, I think that no crisis exists, is false.

We do not need further analysis of the situation to see what is wrong and what needs to be done. Data are being gathered to track the progress of the situation and these data will remain necessary and valuable in assessing what happens as we put corrective measures into action.

Those corrective measures include widespread reform of the tort system, as our college and others have detailed elsewhere. It includes as well a broad educational program to inform the public how seriously our health care system is being adversely affected by the professional liability crisis.

This growing perception by the public will be supported and reinforced by their recognition of the crisis in the entire system of liability insurance for products, for administration of private and governmental organizations in cities, counties, and States, and in every facet of our daily life involving risk and compensation. The college is not here, Mr. Anthony, for narrow pleading of self-interest, but rather to emphasize the severity of the crisis in many ways I have not even suggested. We stand ready to answer questions or to provide assistance in your efforts to bring this under control by national legislative action.

Thank you.

[Attachments to the statement follow:]

RATES FOR NEW HAMPSHIRE MEDICAL MALPRACTICE JOINT UNDERWRITING ASSOCIATION

CLASSIFICATIONS	LIMITS IN THOUSANDS						EFFECTIVE JULY 1, 1984		
PHYSICIANS	25/75	100/300	200/600	250/500	250/750	500/1,000	500/1,500	1M/3M	1M/[illegible]
Class I - No Surgery (other than incision of Boils, Suturing of Skin) or Obstetrical Procedures	1,145	1,569	2,071	2,181	2,212	2,573	2,636	3,044	3,311
Class II - Minor Surgery, Assisting i major surgery on own patients or Obstetrical Procedures - not major surgery, Needle Biopsy, Radiopaque dye Injections, Myelography ...	2,062	2,824	3,728	3,925	3,982	4,631	4,744	5,479	5,950
SURGEONS Class III - General Practitioners assisting in major surgery on other than own patients, including Catheterization (Not including Cardiac Surgery), Ophthalmologists, E/R Physicans - no major surgery, Acupuncture, Radiation & Shock Therapy, Arteriography	3,507	4,804	6,581	6,678	7,014	7,879	8,071	9,416	10,377
SPECIALISTS Class IV - Urologists	4,613	6,407	8,778	8,906	9,354	10,507	10,764	12,558	13,839
Class V - Surgery: Laryngology, Cardiac, General, Othrhinology, E/R w/Major Surgery, Otology, Otorhinolaryngology, Rhinology, Abdominal, Anesthesiology	5,766	8,008	10,971	11,131	11,692	13,133	13,453	15,696	17,297
Class VI - Surgery: OBS, GYN, Plastic, Hand, Head & Neck	6,918	9,609	13,164	13,357	14,029	15,759	16,143	18,834	20,755
Class VII - Surgery: Thoracic, Vascular, Orthopedic, Neuro, Cardiovascular Disease	9,225	12,813	17,554	17,810	18,707	21,013	21,526	25,113	27,670

Responses to Question #4 on Medical Liability Questionnaire: Please state in what way you may have had to alter your field or practice in order to be able to pay your medical liability premium. Has there been any restriction on what you have been able to do in the past? If so, name specific procedures or areas of surgery.

Anesthesia

In early 1984, went on part-time schedule. Because of new government regulations had to change billing system...this coupled with increased malpractice premiums has been disastrous. May have to retire completely if further increase in premium - earlier than planned.

Reduced annual salary (4 MDs 4 CRNAs) to pay premiums; have not been able to fully fund retirement plans and had to file for extension on IRS.

I had hoped to slow down my practice volume as I approached retirement. Because of this confiscatory insurance cost, I will have to work full tilt and then abruptly quite, causing my patients a loss of my expertise and causing me an inadequately funded early retirement.

Over the past few years we have had to make small increases in our fees to attempt to pay for the increase in ML premiums. There is no way that we can change our practice to fall into a lower medical liability category.

raise equipment $5,000/year; raise lab test $60/patient...both only for legal reasons.

Difficult to recruit new associates when cost of malpractice is so high. We are forced to take on every in our hospital - good risk and bad alike - we cannot refuse care to anyone for any reason - we are at the mercy of the JUA.

No alterations yet. Fortunately I'm close to retiring and the premiums just help me to make up my mind to retire sooner.

Less income. Inability to work part-time or slow down....the premium is too high to allow slow-down.

Increase fees. Increase workload.

Raise prices. Open a line of credit.

No change in current practice. I am however planning to seek employment outside clinical medicine. Other alternatives are VA employment or transfer to a state where income, relative to insurance costs, is higher. Another possibility, which I am seriously considering, is early retirement.

In the past some of our nurse anesthetists performed regional anesthesia, because of malpractice problems, we have restricted this although that makes no differences in our premiums. In order to best serve all patients, we have not restricted our practice by type of anesthesia (except as above) or procedure. Therefore, unfortunately, we have had to cover increased premiums by passing on the casts to our patients in higher fees. One of the factors influencing hiring more physicians vs. nurse anesthetist is the difference in malpractice premiums (as well as other salary differentials), it is economically sounder to hire nurse anesthetists rather than provide physician anesthesiologists.

Work harder.

Am serving small hospital. Income generated is unpredictable. May have to start assisting to generate extra income. Malpractice charges may force doctors from small hospitals and patients will ultimately lose out.

I do not practice every day but about 40 hours/week. If the insurance goes any higher, I will have to stop.

No changes or alterations were necessary.

Lower income from practice and also makes it impossible to do anything but full-time practice.

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JBS FREQUENCY ANALYSIS FOR NH MEDICAL SOCIETY

ON QUESTION # 1, FIELD OF PRACTICE? (RESPOND A-O), SELECT ONLY AN   AnesThesiology

ANALYZE QUESTION # 2, MEDICAL LIABILITY % OF GROSS? (RESPOND 1-7)
0-10%         11-20%        21-30%        31-40%        41-50%        51-60%        61-100%
 4             11            3             1             0             0             0
ON QUESTION # 1, FIELD OF PRACTICE? (RESPOND A-O), SELECT ONLY AN

ANALYZE QUESTION # 3, MEDICAL LIABILITY % OF NET?   (RESPOND 1-7)
0-10%         11-20%        21-30%        31-40%        41-50%        51-60%        61-100%
 2             6             7             3             1             0             0
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Emergency Medicine

Overall fees have been raised in the ER to meet the premium. We probably also charge employees who are seen in the ER for care more often than before the increases.

None at present. Would not resume obstetrics if ever returned to family practice. Approximately 30% of x-rays and laboratory I would consider unnecessary in the strict medical sense, but are done because of potential medical liability or because the patient will be a litigant in some other way.

No longer in private family practice - semi-retired - still attempting to prevent malpractice situations by providing high quality care but I am concluding this is an inappropriate appraoch to preventing malpractice claims.

It is difficult to attract physicians from other regions when the malpractice overhead so erodes our net income.

Grin and bear it. Have not yet had to give up procedures re. malpractice costs. It does, however, force certain defensive practice habits upon me, i.e. no matter what the cost I musn't ever be wrong. The malpractice climate infuses the physician/patient relationship with a subtle adversarial poison.

I have not changed the field or manner of practice. I have had to curtail my standard of living to compensate for loss of spendable income. I am 64 years of age. Because of impediments which stand in the way of my medical practice, not the least of which is malpractice premiums, I plan to retire next year, instead of waiting until age 70.

Increase charges.

Stopped giving I.V. analgesia for setting fractures - stopped setting most fractures.

Having done a residency in general surgery I was actively assisting in major cases. However, the new premium rates would add $7,000 in order for me to assist on "other than my own patients" and would raise my rates to almost 20% of my gross income. I think this is ridiculous considering the fees you do receive for assisting. As a result I've had to drop my surgical assisting privileges. In small hospitals this creates a problem since assistants are not readily available especially for difficult major cases.

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JSS FREQUENCY ANALYSIS FOR NH MEDICAL SOCIETY

ON QUESTION # 1, FIELD OF PRACTICE? (RESPOND A-O), SELECT ONLY EM

ANALYZE QUESTION # 2, MEDICAL LIABILITY % OF GROSS? (RESPOND 1-7)
0-10%      11-20%      21-30%      31-40%      41-50%      51-60%      61-100%
 7          4           0           0           0           1.          0
ON QUESTION # 1, FIELD OF PRACTICE? (RESPOND A-O), SELECT ONLY EM

ANALYZE QUESTION # 3, MEDICAL LIABILITY % OF NET?   (RESPOND 1-7)
0-10%      11-20%      21-30%      31-40%      41-50%      51-60%      61-100%
 3          6           2           0           0           0           1
```

Emergency Medicine

Family Practice/General Practice

Increase in fees for patient visits, order more lab tests for defensive medicine, ask for more consultations, raising cost to patient or third party.

Have eliminated procedures (eg TOP's) because cost for malpractice is more than income for the procedure, certainly has contributed to our need to raise office charges; has increased caution and possibly affected the ordering of blood/x-ray tests.

I have already altered my medical practice. I was a general surgeon but because of the high premiums and the decrease in surgery, I am now a general practitioner.

I have eliminated all minor surgical problems and no longer assist in surgery on my patients.

Present practice started Sept. 1983. I've stayed iwthin the specific bounds delineated per contract with carrier and referred what lays outside those bounds on to other doctors.

I have ceased to do any surgical assists because the increased premiums are not warranted by the income I was generating.

Not particularly. We are probably very under-covered with only 100,000/300,000. God help us if we get sued. The above figures are averaged for the two family physicians (who are married to each other) who share the practice.

Restricted liver biopsies. Increase in fees was necessary by 23% over 3 years.

Give up OBS (premiums were 2-3 times more).

Do not assist on surgery on patients other than our own. No ED work.

I don't do things that I feel are risky - this includes OB, being present at school sporting events, assist in surgery on other than my own patients.

We may have to discontinue doing obstetrics in the future if malpractice liability increases for doing obstetrics. Our hospital is served only by FPs doing OBS so this might have a drastic effect on OBS at the hospital.

No minor surgery apart from suture lacerations in order to keep in Class I; no circumcisions; no reduction of fractures or dislocations.

Discontinuing assisting at surgery.

Changed classification: no longer able to do surgical assists, vasectomys, or set fractures.

Eliminate emergency room.

I have discontinued assisting in surgical operations on my own patients. I do more tests (blood & x-ray) and requst more follow-up appointments.

I have given up surgical assisting both for my own patients and those of other physicians because the amount of money this activity brought in did not equal the amount of additional premium I would have had to pay.

See higher number of patients; certainly practice defensive medicine ordering more lab tests and x-ray procedures, stop doing OBS and any surgical assisting.

Increase fees.

Have had to stop assisting in surgery on patients other than our own; practice defensive medicine, raised our fees.

Have dropped epidural anesthetics for delivery hence reducing premium by more than half.

None, except as relating to overall decision not to practice obstetrics.

Stopped obstetrics, stopped assisting at surgery on any patients, continue to practice defensive medicine - even more than previously, raised fees to cover malpractice rates.

Gave up all surgery in the office and hospital and also surgical assists in order to cut down premiums.

Have eliminated all procedures which would prevent level I classification. Gradually, we have given up surgical assisting, emergency room work, circumcisions. We accept new patients only when screened by my staff or recommended by an established patient. We rely less on 25 years of practice experience and refer more.

Do no assist in surgery on patients other than my own. Do not work in the ER.

We are no longer assisting in surgery on our own patients.

Increase number of patients seen daily.

Stopped doing OBS.

Next year I will be dropping coverage to assist on major surgery on other than my own patients. I will also not be able to do part-time ER work starting in June. Finally, I will not be able to put in swan-ganz catheters or do tubal ligations next year because I will be dropping down to a lower class because of cost.

Have only been in practice in NH for a little over a year. I am currently practicing the full extent of my specialty, including routine obstetrics, D&Cs, and ER coverage. However, if premiums continue to rise I will have to make some choices.

I am most concerned that liability premiums for simple, uncomplicated obstetrics not be boosted to the same level as operative OB/GYN. This would "price" the FP out of competition because of the relatively low numbers of patients involved. I do not believe normal OB to be a high-risk situation, and cannot accept an increase in premium for the adequately trained FP to add OB to his practice.

I have reduced practice in taking early retirement, anticipating doing (1) house calls, (2) insurance exams, (3) locum tenens, (4) part-time ER. Insurance requirements prohibited (4) part-time ER because an additional premium exceeding part-time remuneration was to be rquired in spite of coverage provided by the ER.

None, it just raises prices.

Had to discontinue doing epidural anesthesia for labor patients (was adding approx. $6,000 to premium 1 year ago) and now must use a much less safe method - I.M. demerol.

I have cancelled all surgical assisting my own/other doctors patients; obstetrics; fracture treatment.

Have had to stop doing major surgical procedures and plan to stop doing assistants work on patients other than my own.

Considering dropping obstetrics.

Not able to assist at surgery in other than my own patients.

Limit amount of welfare payments. Did not become or accept assignment on all medical services. As many family members as possible employed here.

Dropped assisting at surgery and ER work.

I assist with surgery on my patients, which I feel is a benefit to the patient and myself. It now costs me an additional $2600/year to do this so I barely cover the cost and may have to eliminate this service to my patients.

I have been considering giving up T&As and assisting on other than my own patients.

Work harder and borrow money.

Will not do dilation and currettage for completion of miscarriage and assist surgery/ER only on own patients.

Serious consideration has been given to stop doing OB because of the increased malpractice rates spread over small number of cases in this rural area. Also assisting in surgery. Each of these will be done by other MDs who would charge appreciably more for the same service.

No longer work in ER. Strongly considered dropping liver bx/swan-ganz placement due to higher premium of Class II vs Class I.

Do not apply casts any more. Do not cover ER any more.

I have stopped doing OB work; assistance in surgery on all patients including mine; emergency medicine, selected surgical procedures altogether.

I have stopped all surgical and orthopaedic fracture care procedures. I have stopped assisting at surgery on my own patients which I feel renders less than the best care in the latter instance and increases cost to my patient in the former instance.

I do not do obstetrics or ER because of premium costs. Because I am in the lowest premium category I cannot assist in surgery on my own patients.

No longer do surgery - only assist on my own patients. No longer cast simple no displaced fractures.

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JRS FREQUENCY ANALYSIS FOR NH MEDICAL SOCIETY

ON QUESTION # 1, FIELD OF PRACTICE? (RESPOND A-O), SELECT ONLY FP/GP

ANALYZE QUESTION # 2, MEDICAL LIABILITY % OF GROSS? (RESPOND 1-7)
0-10%        11-20%       21-30%       31-40%       41-50%        51-60%       61-100%
 73           8            1            0            0             0            0
ON QUESTION # 1, FIELD OF PRACTICE? (RESPOND A-O), SELECT ONLY FP/GP

ANALYZE QUESTION # 3, MEDICAL LIABILITY % OF NET?   (RESPOND 1-7)
0-10%        11-20%       21-30%       31-40%       41-50%        51-60%       61-100%
 41           27           9            4            0             0            1
```

Family/General Practice

General, Plastic, Neurosurgery

Have not had to alter practice at this time although does prohibit potentially taking on associate.

Have carefully screened patients for elective surgery - no procedures have been deleted. Rapid rise in costs have essentially meant reciprocal loss in personal income.

I have hesitated increasing my fees because of the weakness of the economy and there has been no increase this year despite a jump of 30% in my premiums. I did increase my fees that I charge lawyers.

Continued escalation of fees for service. No restrictions so far.

Increase fees that I can't collect but can "write-off." Reduce expenses. Do more assisting of other surgeons.

I have had to totally give up the peripheral vascular and thoracic part of my practice - very unwillingly - to continue would have cost an additional $6000+.

So far I have not altered my practice but I may do so over the next few years.

Have stopped doing surgical procedures that increase the risk and thus the premium, i.e. vascular and thoracic.

Presently considering restricting my practice to purely general surgery. Also considering relocating to an area where survival as general surgeron with vascular and trauma is more likely. My practice and consequent medical care for a rural community is in severe jeopardy.

Raise fees 8-10%, eliminate surgery where increased cost of insurance does not cover returns from surgery (e.g. some hand surgery, some head and neck surgery, no vascular or thoracic surgery), take loans to cover malpractice premiums.

Provide less reduced rate or free care. Pursue delinquent accounts more vigorously.

No restrictions as yet, just increase in fees.

Increase charges to patients. Practicing only "my specialty."

Drastic increase in charges.

Give up major surgery. I already gave up reconstructive surgery.

No vascular or thoracic surgery.

None so far but if it goes higher I will have to alter practice.

I have had to do more ER coverage (working as an ER MD) as there has not been sufficient general surgical work. I now work 7-8 days/month in the ER (about 40 hours/week).

I have gone to fewer out of town meetings because of cost (and loss of work while away). I have deleted elective vascular & change surgery to keep cost of insurance down. This problem and the constant inane intrusions into medical practice by the state PRO and other government agencies would make me think twice about going into medicine again.

Stopped doing peripheral vascular surgery - are prohibitively expensive.

Have obtained medical liability through Massachusetts because the cost is too high in NH. (from Salem)

I work harder and have less to show for it. I practice defensive medicine and tend to over order studies to protect myself from possible suit.

The means in which I have decreased my exposure is that cases of moderate difficulty with questionable good outcome, I have referred to medical centers in Boston. I feel that I could have handled them adequately but with the potential of less than satisfactory results I feel it would increase my exposure. I realize that by sending the patient to these medical centers the cost of care delivered to them in Boston is much higher than it would be here in NH without any real improvement in capability of delivering it. Specifically, peripheral vascular disease cases where run-off is marginal and chance of success is also low would be a type that would be send to Boston. The most significant way in which it has altered my practice is the fact that I am leaving NH because after all fixed expenses are covered what is left over for my own personal use is insignificant compared to the time and effort I put into the profession to generate the money to cover these outrageous premiums.

I have discontinued vascular and thoracic surgery in order to reduce my premium from $25,000 to $18,000. I avoid ER referrals whenever possible.

None yet - I am considering dropping chest and vasc. surgery as the extra expense is not worthwhile.

Increase fees for all patients to defray [illegible] of vascular and thoracic surgery extra premium. Stop any "free" or complimentar[illegible] or consultation including second opinion program. Refuse all but emergency "welf[illegible] or non-paying patients.

Limited ability to purchase new equipment. Restricted vascular and thoracic surgery.

I discontinued doing GYN surgery or fracture work because of the high additional premium. I had been doing this type of work following my surgical training for approximately 28 years before the above described discontinuation.

Limiting practice to area of lower premium and leaving practice sooner.

Increased fees to help pay for increase in malpractice premium. If increases continue and I am not allowed to increase fees to cover (i.e. Medicare freeze) would be forced to stop gyn, plastic, hand, head and neck surgery.

Eliminate thoracic and hand surgery. Get more consults and 2nd opinion than are medically necessary. Increase number of tests ordered to CYA.

have discontinued doing vascular and thoracic surgery. I am working longer hours and king fewer vacations.

almost have had to give up some types of surgery due to pressures-to take care of the eds of patients in this areas we have not (i.e. vascular and chest).

have increased my surgical fees to compensate the increased premiums. There have en no restrictions or actual change in practice patterns.

have dropped all gyn, orthopaedic, thoracic and peripheral vascular surgery and limited practice to abdominal and endocrine areas.

thoracic/vascular surgery; no hand, tendon repairs; the increase premium $ has resulted increased fees - not fair to the public <u>but</u> there's no alternative. The "system" won't lerate these increases forever.

es have had to be increased enormously to pay premium of $31,000/surgeon.

ise fees to the maximum extent permissable under third party payments.

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JSS FREQUENCY ANALYSIS FOR NH MEDICAL SOCIETY

ON QUESTION # 1, FIELD OF PRACTICE? (RESPOND A-O), SELECT ONLY GS

ANALYZE QUESTION # 2, MEDICAL LIABILITY % OF GROSS? (RESPOND 1-7)
0-10%          11-20%         21-30%         31-40%         41-50%         51-60%         61-100%
 22             29             6              0              0              0              0
ON QUESTION # 1, FIELD OF PRACTICE? (RESPOND A-O), SELECT ONLY GS

ANALYZE QUESTION # 3, MEDICAL LIABILITY % OF NET?   (RESPOND 1-7)
0-10%          11-20%         21-30%         31-40%         41-50%         51-60%         61-100%
 2              19             20             10             5              0              0
```

General, Thoracic Vascular
Plastic + Neurosurgery

Internal Medicine

I changed coverage to 500,000/1,500,000. Used to carry 1,000,000/3,000,000.

None, except less income.

Less vacation. No raise in 7 years.

I no longer assist at surgery on my own patients. I've raised my charges enough to cover the increased premium.

I am a fully board certified cardiologist yet I have stopped implanting temporary pacers and pulmonary-artery catheters because I was losing nearly $3000 annually because of the additional coverage needed. Also, I try to avoid defensive medicine and am pressured to obtain some tests because of the malpractice atmosphere.

Increase cost to patients.

I gave up my ER duties (2-3 times a month) because of the increase in liability premiums in that area of medicine. Additionally, I would also make the observation that I order many more tests and request many more consultations than my judgment would indicate are turly necessary in order to rule out diagnoses of a very low order of probability.

I gave up ER work.

I have had to stop taking ER call (a problem in our small rural hospital) because the cost of the additional coverage made it impossible to work on an infrequent basis (to help out the others doing it). It is hard to define how much "defensive medicine" I practice - not much in our area.

Have restricted all invasive procedures and practice in more conservative medico-legal conscious manner. Have essentially stopped all pulmonary practice.

Price increases to patients.

No essential change in practice style, however, the tendancy exists to increase the numbers of procedures to offset increase practice overhead. I do not do a complete permanent pacemaker implant but not for liability reasons.

Raise fees.

Have not restricted myself although in order to remain in my present classification I must limit myself to a certain number of balloon tipped hemodynamic catheters per year. So far not a problem but if volume increases dictate need for more procedures then I will have to decide whether or not to accept the increase in premium or limit the numbers accordingly. Of note: When I began placing swan ganz catheters, the increase in liability premium exceeded the gross income from the procedure. Presently, I break about even!!

No kidney biopsy. No surgery of any kind. No invasive procedures.

In the past I have assisted surgeons in the care of patients not defined as my own. Becasue of the increased premiums I have stopped providing this service.

I no longer assist in the OR on my own patients - a popular and enjoyable past practice which would increase my malpractice insurance costs by far more than it would yield in income.

Will not participate as assistant to surgeon on cases other than my own.

Gave up doing any liver biopsies. I had done these for the past 15 years and never had a complication but could not afford the extra malpractice cost.

Reduction in invasive cardiovascular procedures.

Sometimes practice "defensive medicine."

I cannot afford to do certain procedures that I have been trained to do because the jump in class would mean an increase of medical malpractice of $7,000+.

In order to keep my liability down to Class I I have stopped doing the following procedures that I am well qualified to do: Needle biopsies of liver, pleura and bone. I am also the only one within a 35-minute radius who knows how to insert emergency pacemakers and swan ganz catheters and I discourage their use in order to keep my premium down.

None, but my partner has had to stop working in the ER one night a week becuase of a $6092 surcharge.

As liability costs increase this is passed on to my patients as higher cahrges.

Mine is a new practice and I had to borrow the initial premium which represented 25% of all the money I borrowed to start my practice. I practice critical care in a rural area - for my insurance class the number of procedures I do does not pay the premium differential (difference between Class II and Class III). In other words I perform swan-ganz catheterization and temporary pacemaker implantation for free. Yet, these are very often procedures essential to a patient's very survival.

Raise rates.

Stopped assisting on surgical cases.

Stopped ER work and surgery assisting.

Greater use of EKG, x-ray and laboratory services. Greater use of hospital - for instance patients with chest pain are admitted to the intensive care unit with lower suspicion of myocardial ischmeia than previously. Certain procedures (for instance, insertion of Swan Ganz catheters) not done because doing them would put me in a higher malpractice insurance premium category. Certain higher risk procedures (for instance, pericardiocentesis) no longer done although qualified to do them and previously done without mishap. More frequent referral of seriously ill patients to othe rfacilities.

Charges have risen and I practice more defensive medicine because of concerns about lawsuits.

Borrow money.

I have stopped ER work because of high malpractice premium. I do not do pleural biopsy.

Increase fees. Stop ER work. No procedures directly outside my immediate field of practice.

No longer do invasive procedures such as liver biopsy, bone marrow biopsy - call a consultant to do this.

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JSS FREQUENCY ANALYSIS FOR NH MEDICAL SOCIETY

ON QUESTION # 1, FIELD OF PRACTICE? (RESPOND A-O), SELECT ONLY IB

ANALYZE QUESTION # 2, MEDICAL LIABILITY % OF GROSS? (RESPOND 1-7)
0-10%          11-20%         21-30%         31-40%         41-50%         51-60%         61-100%
 72              3              1              0              0              0              0
ON QUESTION # 1, FIELD OF PRACTICE? (RESPOND A-O), SELECT ONLY IB

ANALYZE QUESTION # 3, MEDICAL LIABILITY % OF NET?   (RESPOND 1-7)
0-10%          11-20%         21-30%         31-40%         41-50%         51-60%         61-100%
 50             21              9              0              0              0              0
```

Internal Medicine

Neurology

Introduction of chemotherapeutic agents into CSF - procedure essentially doubles the premium.

Restricted the number of Medicaid and Worker's Comp. cases seen per month; borrowed money to pay bills on time.

My malpractice rate was cut 2/3rds in switch from Aetna to Penn Casualty coverage.

I no longer do a large number of contrast procedures - and am considering discontinuing arteriography.

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JSS FREQUENCY ANALYSIS FOR NH MEDICAL SOCIETY

ON QUESTION # 1, FIELD OF PRACTICE? (RESPOND A-O), SELECT ONLY NEW

ANALYZE QUESTION # 2, MEDICAL LIABILITY % OF GROSS? (RESPOND 1-7)
0-10%        11-20%       21-30%       31-40%       41-50%        51-60%       61-100%
 5            0            0            0            0             0            0
ON QUESTION # 1, FIELD OF PRACTICE? (RESPOND A-O), SELECT ONLY NEW

ANALYZE QUESTION # 3, MEDICAL LIABILITY % OF NET?   (RESPOND 1-7)
0-10%        11-20%       21-30%       31-40%       41-50%        51-60%       61-100%
 3            2            0            0            0             0            0
```

Neurology

Obstetrics and Gynecology

Have increased fees in direct proportion to increased insurance cost. Also have probably increased testing procedures to decrease litigation risk. If premium in obstetrics continues to increase, would probably consider discontinuing OB services.

Until Feb. '85 my annual premium has been just less than $3000 (thru ACOG), from that date it will be approximately $18-20,000. I have made no restrictions. I am currently exploring opportunities with pharmaceutical companies and shall have to retire from practice.

I seem to ask for 2nd opinions on more frequent basis. Do more expensive diagnostic procedures. Seem to refer patients for even slightly complicated conditions to tertiary centers. In short, my income is going down rapidly and the expenses growing daily. How anybody can contain costs is beyond me. I do not have large savings to pay the insurance carrier - so patients will have to bear the brunt - so cost containment and fee freeze is a joke of the year.

Malpractice insurance increased from $7,000 to $17,000 - only alleviation is to increase charge of course.

Cost probably passed on to patient.

The liability situation has made it necessary to pass costs along to the patient. There have been no changes in our practice because of this.

May have to give up the practice of OBG.

I have become more cost conscious; fee increases required to offset increases in malpractice, I have not stopped any part of practice due to same.

Raise fees, but can't increase them to level needed to cover increased premiums. Worry and fret. Search for alternative career.

Rates have increased 300+% in one year with ACOG insurance plan. Plan for future: increase fees, give up OBS or both, suffer along.

We have recently had a major increase in premium which made a significant fee increase necessary.

My malpractice went from $2500 with ACOG to $20,000/year. With this tremendous increase I had to raise fees.

Joined a multispecialty group. No restrictions on actual practice.

No restrictions, just more stress.

No changes yet. Just very cautious. Have considered a career change.

Increase fees to pay the premium. Practice defensively and order more tests than necessary thus increasing costs.

Increase diagnostic tests; increase fees, charge for previously uncharged procedures; limit Medicaid.

Increase fees greater than would have; practice defensively including referring certain high risk obstetrical patients not from medical necessity but primarily to avoid liability.

Raise fees 20% in the pst 12 months to compensate for over a 500% increase in medical liability premiums in one year. No restrictions in the past, but I now refer more complicated or high risk patients.

Have had to raise fees.

I have had to increase fees dramatically. I still perform all procedures that I was trained to do. I am seriously considering discontinuing the obstetric practice. I no longer enjoy this specialty where a less than good result invariably results in a request for patient records and in many instances valuable time spent with lawyers instead of time spent caring for the public.

Drop IUDs, saddle blocks, obstetrics; more ultrasounds, x-rays and lab work; more consultations with other physicians.

I was doing all right until 9/6/84 when I received a letter from the ACOG carrier stating that my annual premium for malpractice insurance was being increased from the former $2875 to $14,430, a 500% increase. I was told that the increase was made necessary by the acturial situation of the OBG specialists in NH "a few old cases have been filed recently and we found our premiums were far too low," is what I was told by an agent. I have just turned 77 and my practice now is very small but I stopped practicing obstetrics as of 10/31/84. I can get insurance to cover my practice of gynecology, female urology, and female infertility and endocrinology now for $10,700 a year. I still have some loyal old patients who want to come in to see me and I have a few major gyn operations to do, maybe after the Holidays. I thought I'd give it a try for another quarter, to see if I can "break even," when I compare my practice expense with my gross income. As long as there is any reasonable net income from practice, I'll probably continue as long as the patients come in. I've been informed that if I do no surgery or OB at all and just do general office practice, my annual premium will be about $3900.

I believe some of the other physicians doing obstetrics and filling a valuable local need where they practice, but who delivery only 20 or 30 babies a year, will probably balk at the nearly $15,000 annual premium and quit obstetrics. This will mean that the women of NH may have to travel many miles to the larger towns & hospitals to get prenatal and hospital obstetrical care, which will be a real hardship on them.

A 52-year-old OBG in the Detriot area, who I taught as a medical student when I was Prof. & Chairman of the Dept. of OBG at Wayne State University School of Medicine (where I taught for 24 years & retired at age 65 in Dec. 1972, & came here to live & be a "country doctor") who is well trained, a diplomate of the American Board of OBG & recertified recently, was coming here to practice in Wolfeboro & take over what's left of my practice, but when he learned of the 500% increase in the premium he backed off & is staying in the Detriot area. He would have been a real addition to Carroll County medicine and a help to women here. I'm really disappointed. Whatever happened to our JUA that we got into such a hole?

Ob Gyn

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JSS FREQUENCY ANALYSIS FOR NH MEDICAL SOCIETY

ON QUESTION # 1, FIELD OF PRACTICE? (RESPOND A-O), SELECT ONLY OBG

ANALYZE QUESTION # 2, MEDICAL LIABILITY % OF GROSS? (RESPOND 1-7)
0-10%          11-20%         21-30%         31-40%         41-50%         51-60%         61-100%
 18             9              4              0              0              0              1
ON QUESTION # 1, FIELD OF PRACTICE? (RESPOND A-O), SELECT ONLY OBG

ANALYZE QUESTION # 3, MEDICAL LIABILITY % OF NET?  (RESPOND 1-7)
0-10%          11-20%         21-30%         31-40%         41-50%         51-60%         61-100%
 4              11             7              7              1              1              1
```

Ophthalmology

Modest fee increases are the only way to compensate for rising costs of malpractice coverage.

I've had to increase fees and limit Medicaid work.

One year ago fees were raised to keep up with the escalating premiums. We have not restricted our surgery as yet.

Increases in malpractice premium are reflected in increased fees - with the present voluntary freeze on fee increases (including Medicare's less voluntary measures) I do not know what I will do if malpractice premiums rise again.

As a result of the rising cost of liability insurance, I am unable to purchase the equipment needed to keep up to date in my field. Ophthalmology has a high level of overhead as it is.

Defensive medicine. Expensive tests only to cover the possibility of alleged malpractice rather than clinical acumen of most likely causes and Rx's - e.g. headaches.

Have already stopped major surgery and am seriously considering early reitrement - malpractice insurance is not entire reason but certainly plays a good part. It is not possible to "slow-down" practice, economically. Last medical liability premium $9005.

To reduce my premium I have eliminated part of the surgery I am trained to do because it would cost too much.

I try to charge more to make up the lost income. No change in my practice, however.

Raise my fees to cover the cost. Ophthalmology is being "ripped off" in NH. I am paying about $10,000 as Category III or $1,000,000/$3,000,000. The same coverage is $4,400 in California. Even New York and Massachusetts is less than NH.

The cost has affected me in two ways. (1) I am now unable to purchase some expensive forms of therapy, such as a laser. It also makes me more cautious than I probably should be. It also is a major problem to consider paying the higher malpractice premium in one lump sum and I find it unpalatable to have to pay a finance charge if it is to be paid on installment basis. Another payment schedule would increase the ratios listed in #2 and #3 above by a few percentage points. I will also be obtaining a list of what procedures I could eliminate to decrease my malpractice risk classification. A rural setting as the only ophthalmologist and it may affect what procedures I would offer or decline to give my patients.

Stopped intraocular surgery about three years ago.

Fewer or less frequent capital improvements equipment purchases; understaffing; there is a tendency to consider the remmuerative aspects of practice as essential for the payment of escalating premiums. Pursuing delinquent accounts much more aggressively. Much more difficult to offer free services to charity cases - when one realizes that they can sue just as effectively as anyone else. No restrictions, in fact, trying to enhance surgical repertoire to help out.

Give up all but one office telephone. Reduce office overhead by closing office completely one day a week. Reduce donations drastically. Cut back attendance at distance medical meetings. I probably will have to cut out retinal surgery or corneal transplants (which I have done for years) because of the excessively high premiums involved.

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JSS FREQUENCY ANALYSIS FOR NH MEDICAL SOCIETY

ON QUESTION # 1, FIELD OF PRACTICE? (RESPOND A-O), SELECT ONLY OPH

ANALYZE QUESTION # 2, MEDICAL LIABILITY $ OF GROSS? (RESPOND 1-7)
0-10$          11-20$          21-30$          31-40$          41-50$          51-60$          61-100$
 21             2               0               0               0               0               0
ON QUESTION # 1, FIELD OF PRACTICE? (RESPOND A-O), SELECT ONLY OPH

ANALYZE QUESTION # 3, MEDICAL LIABILITY $ OF NET?   (RESPOND 1-7)
0-10$          11-20$          21-30$          31-40$          41-50$          51-60$          61-100$
 12             11              0               0               0               0               0
```

Ophthalmology

Orthopaedic Surgery

Have had to increase fees - practice unchanged.

I may have to stop doing surgery completly, eventually retire.

Looking at alternative states to move my practice to.

No restrictions - increase in charges have been necessary.

Work harder to increase volume instead of having an associate to share in the practice.

No change in practice but taking <u>much</u> less salary.

I came to NH to practice part-time and pursue other interests such as forestry, land management, and music. I have had to practice essentially full time and limit my other interests because of medical liability premiums.

Fee increases; doing more high pay legal/disability work - less patient care; have stopped doing some high risk surgery (eg. spinal cases); have stopped treating or refer patients to Boston who present with hostility or emotional problems or where needed surgery has high risk of complications or uncertain outcome.

No alternation yet but more of an increase would produce some.

We raised our rates.

My income decreased. I am not able to do anything yet but I am thinking to stop doing major orthopaedic procedure.

Increased fees, no change in procedures performed, increased number x-rays - defensive medicine; do not perform spinal surgery.

Work harder, raise fees on office and surgery, stop participating in BC/BS.

Have had to raise office fees specifically to try and offset rapidly rising malpractice premiums.

Must raise prices to pay for it.

At what point should be the apogee of my career (note that to be a relative apogee) having to consider to D/C surgery. It does seem to be a significant loss of community resources if NH becomes a state that does not do orthopaedic surgery.

All surgical fees raised.

I do not do risky surgery or tak on cases where chances of success are not quite high. (eg revision total hip surgery; "re-do" back surgery). I refer cases that I don't do a lot (even though I feel I could do a good job (eg total knees, scoliosis) because if a complication occurred the 1st thing a lawyer would ask me is "how many of these have you done?"

I have to work harder. There's no way to reduce practice - it's either straight out or nothing.

Have given up major surgery and am doing primarily office work.

Work more days per year; charge higher fees; see more patients per day; hire physician assistants rather than physicians to handle the increased patient load.

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JSS FREQUENCY ANALYSIS FOR NH MEDICAL SOCIETY

ON QUESTION # 1, FIELD OF PRACTICE? (RESPOND A-O), SELECT ONLY ORS

ANALYZE QUESTION # 2, MEDICAL LIABILITY % OF GROSS? (RESPOND 1-7)
0-10%        11-20%       21-30%       31-40%       41-50%       51-60%       61-100%
 19           17            3            0            0            0            0
ON QUESTION # 1, FIELD OF PRACTICE? (RESPOND A-O), SELECT ONLY ORS

ANALYZE QUESTION # 3, MEDICAL LIABILITY % OF NET?   (RESPOND 1-7)
0-10%        11-20%       21-30%       31-40%       41-50%       51-60%       61-100%
 1            13           13            6            4            1            1
```

Orthopaedic Surgery

Otolaryngology

Have raised fees. No practice restrictions incurred.

Plan to eliminate ENT surgery in 1986.

For the first time in my medical practice I must ask the insurance status of ER patients and accident victims because all of my malpractice communication has hinged on uninsured accident or trauma victims seeking sources of financial gain. Although I still treat these people, the number of x-rays, CT scans, and laboratory tests have increased by a significant amount, as have additional medical consultations and clearances for anesthesia and surgery. My elective patient practices including pre-operative evaluations, laboratory studies, and patient counseling have not changed, however, surgical fees have increased to cover the added cost of malpractice insurance. My use of medical consultants for cardiac, pulmonary and genitourinary systems clearance has increased dramatically for those patients of which I was not 100% sure that a problem did not exist. These consultants have been requested out of the need to protect myself from "failure to diagnose liability suits."

I take ample care to practice defensively and refer high risk cases to avoid litigation.

I have increased my rates with each increase in malpractice. As yet, I have not restricted my surgery.

I order more blood chem, x-rays, Catscan, etc., more consultations, more hospitalization; stop doing rhinoplasty or any plastic surgical procedures. I encourage patients to go for second opinion to Boton or wherever they want to go.

No restrictions in practice. Have raised fees to attempt to maintain high level of medical care in order to pay these ridiculously large malpractice premiums.

Will probably stop all surgery in near future.

I x-ray everything now even when they may not be helpful (broken noses, sinus disease).

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JSS FREQUENCY ANALYSIS FOR NH MEDICAL SOCIETY

ON QUESTION # 1, FIELD OF PRACTICE? (RESPOND A-O), SELECT ONLY OTOL

ANALYZE QUESTION # 2, MEDICAL LIABILITY $ OF GROSS? (RESPOND 1-7)
0-10$          11-20$         21-30$         31-40$         41-50$         51-60$         61-100$
 12              2              0              0              0              0              0
ON QUESTION # 1, FIELD OF PRACTICE? (RESPOND A-O), SELECT ONLY OTOL

ANALYZE QUESTION # 3, MEDICAL LIABILITY $ OF NET?   (RESPOND 1-7)
0-10$          11-20$         21-30$         31-40$         41-50$         51-60$         61-100$
 1               9              2              1              1              0              0
```

Otolaryngology

Pediatrics

No longer assist on surgery on my patients because of the increase in premium if I do that will not be offset by the additional income derived from assisting.

We are strongly considering no longer performing ambilical artery catheterization on newborns - our liability classification will thus increase to prohibitive levels due to the invasive characteristic of such a procedure.

Have stopped doing circumcisions and similar other surgical elective procedures.

Normally we would handle more minor orthopaedic and surgical problems in office, now they are referred. Rates were increased this year, only to cover social security and malpractice - we received no increase in net salary.

Increase price of all office and hospital visits - don't assist in any major surgery.

Had to increase my office visit and hospital visit charge. Increase the practice volume by spending less time with each office visit (I used to walk, now I run). I used to take at least 3 weeks vacation per year (from 1968 to 1979). Now I can afford only 10 days vacation including the week-ends involved int he vacation period. Instead of working 5 days a week, my working week days have been increased to 6/week. I can only go out of town for meetings only about once every two years. My wife had to take a full-time job. I cannot affort to send my second son to a private school.......I used to be on top of the medical literature now I don't have the time to do all the reading I need.

I do not do procedures. I frequently find myself practicing defensive medicine at patients cost.

Raise prices.

Fee increases.

Have discontinued intra arterial lines in newborn and referred mostly all ill infants to tertiary centers. Will not assist on non-patients.

Pediatrics

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JSS FREQUENCY ANALYSIS FOR NH MEDICAL SOCIETY

ON QUESTION # 1, FIELD OF PRACTICE? (RESPOND A-O), SELECT ONLY PED

ANALYZE QUESTION # 2, MEDICAL LIABILITY $ OF GROSS? (RESPOND 1-7)
0-10$        11-20$        21-30$        31-40$        41-50$        5'-60$        61-100$
 17           2             0             0             0             0             0
ON QUESTION # 1, FIELD OF PRACTICE? (RESPOND A-O), SELECT ONLY PED

ANALYZE QUESTION # 3, MEDICAL LIABILITY $ OF NET?   (RESPOND 1-7)
0-10$        11-20$        21-30$        31-40$        41-50$        51-60$        61-100$
 15           3             0             1             0             0             0
```

Radiology

Raised charges.

Fees have obviously been raised to help defray this cost.

Much more selective in cerebral angiography and inverventional procedures. I have refused to read films taken by other offices as "curbstone consult." Fees have been increased.

None, but I contemplate withdrawing from interventional radiology.

No longer practice interventional radiology (e.g. angiography); have reduced level of liability coverage and changed classification group.

It has prevented me from venturing into other subspecialties such as interventional radiology.

No restrictions, just added stress.

I have raised my fees to pay premiums; I wish to retire as soon as possible; at least 50% of the examinations I do are not medically indicated - they are done because of the threst of suite, this increases medical cost of radiation exposure; good, caring physicians are being driven from medicine and the practice of good medical care; I categorize the legal profession as despicable.

Will have to increase fees to pass the increased premiums on to patient charges.

Because of the constant threat of a "malpractice" liability suit I find that I can almost never be entirely certain of anything that I need more views, more examinations, other imaging modalities, more follow-up recommendations, all for fear of missing anything. I'm certainly aware of the other aspect of diagnostic radiology - fiz the clinician's need to order many many imaging exams where in past one might have sufficed.

Radiology

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JSS FREQUENCY ANALYSIS FOR NH MEDICAL SOCIETY

ON QUESTION # 1, FIELD OF PRACTICE? (RESPOND A-O), SELECT ONLY RAD

ANALYZE QUESTION # 2, MEDICAL LIABILITY % OF GROSS? (RESPOND 1-7)
0-10%          11-20%          21-30%          31-40%          41-50%          51-60%          61-100%
 15             3               0               0               0               0               0
ON QUESTION # 1, FIELD OF PRACTICE? (RESPOND A-O), SELECT ONLY RAD

ANALYZE QUESTION # 3, MEDICAL LIABILITY % OF NET?   (RESPOND 1-7)
0-10%          11-20%          21-30%          31-40%          41-50%          51-60%          61-100%
 10             8               0               0               0               0               0
```

Psychiatry

I have not altered my practice in any way - I probably have a bit lower income than my peers and will need to increase fees a bit sooner than I would like.

I practice more "defensively," ordering more tests which clinically I suspect strongly will be negative but which must be done to cover myself legally. This obviously raises the cost of care to the patient. I also see patients more frequently, advise less by telephone. Clinically I could practice more efficiently, both for the patient and myself, if it were not for the increasingly threatening malpractice situation.

No longer elect ECT coverage which I wasn't performing anyway.

Very minimal change besides cutting down overhead and minor increase in fees.

Just beginning a practice here in NH has been made difficult because the cash flow problem is exacerbated by the large amount I had to pay in malpractice. I opted for a lower coverage and certainly considered either not opening a practice now (even though needed here) or going without coverage.

I choose not to explore ECT as that would require an increase by 100-200% present liability expenses. So far in psychiatry (with special dispensation from State Insurance Commissioner) prices are reasonable from APA carrier.

Psychiatry

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JSS FREQUENCY ANALYSIS FOR NH MEDICAL SOCIETY

ON QUESTION # 1, FIELD OF PRACTICE? (RESPOND A-O), SELECT ONLY PSY

ANALYZE QUESTION # 2, MEDICAL LIABILITY % OF GROSS? (RESPOND 1-7)
0-10%          11-20%          21-30%          31-40%          41-50%          51-60%          61-100%
 14             0               0               0               0               0               0
ON QUESTION # 1, FIELD OF PRACTICE? (RESPOND A-O), SELECT ONLY PSY

ANALYZE QUESTION # 3, MEDICAL LIABILITY % OF NET?   (RESPOND 1-7)
0-10%          11-20%          21-30%          31-40%          41-50%          51-60%          61-100%
 14             0               0               0               0               0               0
```

Other

Not yet, but if it continues to rise, may have to stop practice or drop insurance coverage. (hypnosis)

Increased fees which my patients have not blamed me for. They understand the malpractice insurance problem, and the "ambulance chasing" by lawyers (who are getting a bad name in the community). (Urology)

High risk surgical procedures are not provided. Minor skin surgery is still performed. Patients are more often referred for a second opinion even though this does not appear necessary. (Dermatology)

I had to increase my office hours to 14 hours a day (at least two days a week) in order to be available to working patients. I had to increase my fees. Just for the acupuncture procedure done only by me, the rates for my insurance doubled, although the acupuncture is not a surgical procedure. It is well known that any MD can insert a needle in almost any part of the human body and inject solutions or medicants through that needle. For this procedure the liability premium is not increased. On the other hand, with the acupuncture procedure consisting of just inserting needles without injecting anything, the liability premium is almost double. It is a paradox. (acupuncture)

It has been necessary to increase fees. No restriction in practice. (Urology)

No change in practice. Am voluntarily slowing to part-time, no relation to insurance fees. However, will shotrly have to quit completely because of decreasing income without compensatory insurance adjustments. (Pathology)

Raised fees. (Urology)

Have considered moving practice to Maine where premiums are much lower. (Urology)

Avoidance of procedures that would be considered cosmetic surgery and thus avoid the premium that would be charged if I did such. (Dermatology)

There is no doubt that the increase in medical malpractice cases has changed the way I practice. More specifically, there are some "cosmetic" surgical procedures that I would no longer consider doing, and thus, would be more likely to refer the patient to someone else who perhaps would be more willing to take a chance on being sued. I also find that I order more laboratory studies, many of which might not be absolutely necessary to cover myself. Finally, I find that I am more included to take a biopsy of a lesion rather than treating it on the initial visit, thus, allowing the patient the opportunity of expressing their desire to be treated elsewhere once they find the nature of the problem. (Dermatology)

Have had to raise our fees. Feel the need to over-examine and over-test. (Urology)

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JSS FREQUENCY ANALYSIS FOR NH MEDICAL SOCIETY

ON QUESTION # 1, FIELD OF PRACTICE? (RESPOND A-O), SELECT ONLY OTHER    Urology

ANALYZE QUESTION # 2, MEDICAL LIABILITY % OF GROSS? (RESPOND 1-7)
0-10%        11-20%       21-30%       31-40%       41-50%       51-60%       61-100%
 20           2            0            0            0            0            0
ON QUESTION # 1, FIELD OF PRACTICE? (RESPOND A-O), SELECT ONLY OTHER

ANALYZE QUESTION # 3, MEDICAL LIABILITY % OF NET?   (RESPOND 1-7)
0-10%        11-20%       21-30%       31-40%       41-50%       51-60%       61-100%
 12           8            1            1            0            0            0
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Mr. ANTHONY. Thank you very much.

Dr. Bagan, you may proceed.

STATEMENT OF MERWYN BAGAN, M.D., ON BEHALF OF THE AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS AND THE CONGRESS OF NEUROLOGICAL SURGEONS

Dr. BAGAN. Mr. Chairman and members of the subcommittee, thank you for the opportunity to appear here today to discuss the perennial and immensely serious problem of medical professional liability. I will summarize my written statement.

I am Merwyn Bagan, M.D., a practicing neurosurgeon from Concord, NH. I speak for the American Association of Neurological Surgeons and the Congress of Neurological Surgeons, which represent more than 2,900 neurosurgeons in the United States.

The problem of professional liability has existed in crisis proportion for a decade. The only differences between 1976 and 1986 are that there are more suits, higher awards, in some cases premium increases of over 300 percent, and that the pervasive nature of the problem now includes community hospitals, child health clinics, engineers, and indeed lawyers. Another difference is best illustrated by my presence at these hearings today and by the several reform bills now pending before the House of Representatives and the Senate. Such was not the case in 1976.

Before I discuss costs and remedies, let me acknowledge certain absolutes.

One, there are incompetent physicians who should be disciplined.

Two, there are legitimate negligence claims for which just compensation should be awarded.

Three, medicine is an imperfect science. To quote Sir William Osler, the practice of medicine is "the practice of an art which consists largely in balancing probabilities * * *. It is a science of uncertainty and an art of probability * * *. Absolute diagnoses are unsafe and made at the expense of the conscience."

Four, there are attorneys who will file a case without merit, and as a result the number of frivolous cases has risen dramatically.

Five, there is, in America a litigious mentality regarding professional or product liability. This attitude demands a risk-free society.

There are no easy answers to this problem; for example, the recently published GAO report—"Medical Malpractice: No Agreement on the Problems or Solutions."

Mr. Chairman, in the last 10 years, 49 States have enacted some degree of tort reform. The resulting impact on the crisis has been mixed at best. It is our opinion that it is now time to find a Federal remedy that builds on the various State statutes.

The cost of medical professional liability has been estimated to be in excess of $12 billion a year. A neurosurgeon in New York State may pay more than $100,000 for insurance in 1986. A recent study put the cost of defensive medicine at 30 percent of the Federal Government's health care outlays. The impact on access to care is very difficult to assess in economic terms.

The changing patterns of delivering health care in certain specialties, such as obs/gyn and neurosurgery, are a serious problem.

For example, in 1985 the 204 practicing neurosurgeons in New York State were surveyed with 94 respondents providing the following information:

Eighty-seven percent of those responding are board certified by the American Board of Neurological Surgery;

One hundred percent spent from 5 to 8 years after medical school obtaining specialized postgraduate training enabling them to deal effectively with surgical diseases of the nervous system;

The average age at commencement of the practice of neurological surgery is 32.3 years of age;

The average age of a practicing neurosurgeon in New York State is 50.6 years;

Thirty-one percent of those responding plan to retire earlier than expected;

Twenty-five and two-tenths percent of those responding are seriously considering moving out of New York State;

Fifty-three and six-tenths percent plan to limit their exposure to neurosurgical problems because of the increased litigious nature of our society;

Sixty-eight percent plan to be more selective in what they do;

Twelve and seven-tenths percent already limit their practice to a small segment of neurosurgical conditions;

One hundred and seventy-two suits are presently currently active against the 94 respondents;

Sixty-five lawsuits were initiated against 44 percent of the 94 respondents in the past year alone;

Seventy-five lawsuits brought against the respondents over the years have been closed without payment before, during, or as a result of a trial; and

Seventy-four percent consider that the problems relating to medical liability constitute their most serious concern.

One respondent has had his personal assets attached as a result of a lawsuit.

Included as a part of my statement is a New Hampshire physicians survey done in November 1984. We think this is important data because it is from a rural and urban State. About one-third—489—of the total number of physicians in the State responded. There were some individuals whose medical liability premium as a percentage of gross or net income exceeded 60 percent. The following physicians' comments are most notable:

One, from an emergency room physician:

> Would not resume obstetrics if ever returned to family practice. Approximately 30 percent of x-rays and laboratory I would consider unnecessary in the strict medical sense, but are done because of potential medical liability or because the patient will be a litigant in some other way.

Two, from an internist:

> I gave up my ER duties—two to three times a month—because of the increase in liability premiums in that area of medicine. Additionally, I would also make the observation that I order many more tests and request many more consultations than my judgment would indicate are truly necessary in order to rule out diagnoses of a very low order of probability.

Three, from an otolaryngologist:

> For the first time in my medical practice I must ask the insurance status of ER patients and accident victims because all of my malpractice communication has

hinged on uninsured accident or trauma victims seeking sources of financial gain. Although I still treat these people, the number of x-rays, CT scans, and laboratory tests have increased by a significant amount, as have additional medical consultations and clearances for anesthesia and surgery. My elective patient practices, including preoperative evaluations, laboratory studies and patient counseling have not changed; however, surgical fees have increased to cover the added cost of malpractice insurance. My use of medical consultants for cardiac, pulmonary and genitourinary systems clearance has increased dramatically for those patients of which I was not 100 percent sure that a problem did not exist. These consultants have been requested out of the need to protect myself from "failure to diagnose liability suits."

Four, from a general and vascular surgeon:

> Presently considering restricting my practice to purely general surgery. Also considering relocating to an area where survival as general surgeon with vascular trauma is more likely. My practice and consequent medical care for a rural community is in severe jeopardy.

Now I would like to discuss the issues of the cost and remedies.

Organized neurosurgery proposes that any Federal solution must incorporate the following in order to assure substantial reform and cost savings:

One, structured settlements: We endorse the California recommendation to the American Medical Association which states any settlement over $50,000 must be structured.

Two, collateral source rule: We recommend the definition included in the Moore-Gephardt bill, H.R. 3084. It reads:

> . . . collateral benefits means all benefits received or entitled to be received by an injured individual under State or Federal laws or any health or accident insurance, wage or salary continuation plan, or disability income insurance.

Three, noneconomic loss: We agree with the decision of the U.S. Supreme Court not to hear an appeal of the California limitation which states,

> . . . that in no action for injury against a health care provider, based on professional negligence, shall the amount of damages for noneconomic losses exceed $250,000.

Four, contingency fees: We agree with the formula contained in the Inouye bill, S. 175: one-third of the amount of an award of less than $100,000; one-quarter of the amount of an award between $100,000 and $200,000; 20 per centum of the amount of an award between $200,000 and $300,000; or 15 per centum of the amount of an award in excess of $300,000.

Five, medical conduct: We agree there must be provisions for quality assurance/risk management. Programs might be based on the models of the California Board of Quality Assurance and the Florida Department of Professional Regulation. Most States are financially strapped. Modest Federal grants to the States, for 2 to 3 years, would strengthen boards of registration in medicine. Investigative personnel could be hired. The State attorney general could designate assigned counsel.

We believe it is possible to develop effective risk management/quality assurance programs. It is possible to have effective disciplinary boards. Only thought and money are needed. Both H.R. 2659, introduced by Congressman Mrazek, and S. 1804, introduced by Senator Hatch contain grant mechanism language.

Six, incentives: The overall adoption, by the States, of this program of tort and administrative reforms should be related to the entitlement programs. We endorse the legislative concept of incentives to the States as a means of accomplishing these reforms.

These reforms would assure that a larger percentage of awards would go to the injured party—plaintiff. The use of defensive medicine would be reduced. This would represent savings in the billions to the Federal Health Care System.

These reforms could dramatically reduce the cost of insurance premiums to physicians. The AMA, using the actuarially firm of Milliman & Robertson, Inc., estimates that as much as $800 million could be saved if the bill they favor, S. 1804, were enacted into law.

These reforms could reverse an alarming trend among physicians who will not perform certain high risk procedures.

Biomedical researchers at our great teaching institutions are withdrawing from their work at the frontiers of knowledge in medicine because of the liability risk. Hopefully, reform would reverse this dreadful trend.

Mr. Chairman, in 1976, there was a professional liability emergency. The patient was treated with a Band-Aid—an attempt at tort reform and the adoption of continuing medical education requirements. For 10 years, the patient has struggled and returns once again in dire emergency. Draconian measures are necessary. We are prepared to cooperate with you as you move to find a cure.

Thank you.

Mr. **Anthony**. Thank you, Dr. Bagan.

Our next witness is Roby C. Thompson, Jr.

STATEMENT OF ROBY C. THOMPSON, JR., M.D., PRESIDENT, AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS

Dr. **Thompson**. Mr. Anthony, Mr. Schulze, I am also a professor and head of the department of orthopaedic surgery at the University of Minnesota, and president of the American Academy of Orthopaedic Surgeons. We have over 12,000 members.

We are among the high risk members of the medical profession for professional liability actions presumably based on the numbers of claims and the size of the awards against our members.

The reasons for this position are not clear. They probably relate to the visibility of our treatment efforts.

For example, when a fractured leg heals with shortening of the limb, it is an obvious defect. The result may be unavoidable by virtue of the injuries sustained, but it is visible.

Expectations of our patients: The advances in orthopaedic care within the last 20 years have led the public to expect near perfect results in most disorders we treat.

Nature of treatment programs we undertake: Many patients today undergo high risk surgical procedures in order to achieve results undreamed of 10 to 20 years ago.

We believe the people of the United States face a crisis in the liability based litigation in many areas of our life, as recently highlighted in the national media. We know our patient population faces a crisis, and we believe the crisis is based on a failure of the current system.

Some of the reasons I would cite for the failure include looking at the distribution of premium dollars in a different way than

Judge Bell did; as little as 20 percent of the premium dollar being returned to the injured patient when one takes into account all overhead as well as legal fees; lack of appropriate response to initiate action with delays up to 7 years in some cases before an action can be determined; inconsistent awards for similar problems.

These failures create adverse effects to the public. These adverse effects now are highlighted by reduced access to quality care and an increased cost of medical care.

We believe that changes must be made in the present system in order to eliminate these problems and request the Congress of the United States in their wisdom to consider acting on these changes.

We would suggest a mechanism be established to reduce the frivolous actions of lawsuits being initiated without cause.

We believe that there should be a modification of the contingency fee system. We believe there should be a structure to the large payment awards, and that there be a limit on noneconomic awards.

I would also like to suggest that we need to establish acceptable criteria for expert witnesses in medical malpractice cases.

We accept the need for our involvement in this process and believe we can contribute to the resolution of the problem by providing increased quality medical education for our practitioners, establishing risk management programs to deal with the rapid advances in medical technology, and by monitoring the standard of care of our specialty and identifying substandard practices through quality control programs.

Mr. Chairman and members of the committee, resolution of this complex problem will require cooperation from the medical, legal, and legislative communities.

I am grateful for the opportunity to appear before this committee and offer the assistance of the American Academy of Orthopaedic Surgeons in reaching a solution to improve the medical care of the public and still provide due rewards to those deserving injured parties.

[The prepared statement follows:]

STATEMENT OF ROBY C. THOMPSON, JR., M.D., PRESIDENT, AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS

Mr. Chairman and members of the committee, I am Roby C. Thompson, Jr., M.D., Professor and Head of the Department of Orthopaedic Surgery at the University of Minnesota and President of the American Academy of Orthopaedic Surgeons. The Academy has over 12,000 fellows, all of whom are Board Certified in the specialty of orthopaedics.

I am pleased to appear before you today to present the Academy's concerns about the current professional liability insurance crisis.

This current crisis in professional and product liability not only affects practicing physicians, but it also affects architects, engineers, certifies public accountants, municipal governments, day-care providers, manufacturers, etc. In short, just about every segment of our society is being adversely affected by the current situation.

The orthopaedic surgeons of the United States are among the "high risk" members of the medical profession for professional liability actions. The reasons behind this are not completely clear, but probably are related to:

1. The visibility of our treatment efforts. When a fractured leg heals with shortening of the limb, it is an obvious defect. This result may be unavoidable by virtue of the injuries sustained, but it is visible.

2. Expectations of our patients. The advances in orthopaedic care within the last 20 years have lead the public to expect near perfect results in most disorders we treat.

3. Nature of treatment programs we undertake. Many patients today undergo high risk surgical procedures in order to achieve results undreamed of 10 to 20 years ago.

We recognize that some patients should be compensated for injuries they suffer during the course of their treatment for musculoskeletal disorders. At the same time it is clear that the most prudent, best educated orthopaedist will not be able to produce perfect results in the care of all patients.

Recently, we published a position paper citing the need for reforms in our tort laws and the way professional liability insurance is written. The major point in that document is that the current system fails to compensate the deserving injured patient at a reasonable cost, and places an undue burden on all patients needing our services. In our opinion, some of the reasons for this failure are:

As litte as 20 percent of the premium dollar may reach the truly injured patient. A disproportionate amount is devoured by legal fees and insurance company overhead.

The system is not prompt. In some areas of the country a plaintiff may encounter delays of up to seven years before a judgement is determined.

Awards are frequently inconsistent. Amounts may vary greatly in similar cases without obvious reasons.

The results of this failure have had adverse effects on the public and professionals alike. Two major effects of this failure are: reduced access to quality care; and increased cost of patient care.

Access to orthopaedic care is being affected in some localities because orthopaedists have moved to other areas; have decided not to accept certain high risk patients or perform certain high risk procedures; or have left the field of medicine altogether by pursuing new careers or early retirement. For example, we have been told by our fellows in Massachusetts that in the Cape Cod area four of the nine orthopaedists practicing there one year ago have since left the state and/or the practice of orthopaedics, as a result of the skyrocketing liability premiums combined with a fee freeze.

The increased cost of care comes from several sources. One form can simply be labled "defensive medicine." The American Medical Association estimates that the health care system incurs an additional $15 billion in expenses due to the fact that many physicians order certain tests not normally indicated in the course of treatment, to avoid potential criticism in the event an untoward outcome results. Another form of increased cost in the fact that physicians are currently paying over $4 billion a year in professional liability insurance premiums.

The Academy fully appreciates the complex nature of this problem, and while affirming the right of truly injured patients to seek redress in courts, offers the following suggested reforms:

Efforts must be made to reduce the number of frivolous cases and those based on questionable merits. One way to do this would be a requirement for plaintiffs to post a preliminary bond, or a public entity to review cases before they reach the courts. Other mechanisms have been proposed which would insure the patient against an adverse event but not limit the right to litigation.

Modify the current contingency fee system, which is not used in other countries, and replace it with a sliding scale. We believe that the contingency fee contributes excessively to the overall cost of the system, while taking away resources from the truly injured.

Current collateral source rules, prohibiting disclosure during litigation of compensation from other sources, should be changed. We believe that losses compensated from other sources of insurance should not be paid again from awards made for professional liability. This "double payment" is a major factor in the escalating cost of the system, and has evolved from an aberration in the legal process.

Large awards should be carefully structured throughout the lifetime of the injured patient. These structured awards can result in significant financial savings. For example, a structured award can be initiated for awards exceeding $250,000. The goal of these structured awards or periodic payments is to provide funds to care for the patient throughout his or her lifetime.

Limiting the amount of non-economic awards – often referred to as pain and suffering. The enormous variation in jury awards, ranging from a few thousand dollars to millions of dollars for similar injuries, indicates the emotional response of different environments throughout the United States. In 1982, the Rand Corporation completed a study that found that the regulation of non-economic awards would significantly reduce the cost of insuring for professional liability.

This point is supported by the fact that the state of Indiana, which has a law limiting the amount of non-economic awards, also has the lowest liability insurance premiums in the country.

The qualifications of expert witnesses need to be sharply defined. We believe that an expert witness should be fully qualified in the specialty involved in the litigation, and should be in the active practice of that specialty. The current system of accepting any licensed physician does not result in expert testimony being presented to the courts.

The statute of limitations need to be shortened. The preponderance of patient injuries are obvious immediately or within a short period of time after treatment. Without a shorter statute of limitations, large financial reserves must be maintained for many years because of the unpredictable economic loss. This is especially true where a minor is involved and a suit can be filed over a period of nearly 20 years. With premiums approaching $100,000 in some states, you can easily calculate how large an insurance reserve must be maintained after a physician retires.

Mr. Chairman, we recognize that in addition to the above legal reforms, the medical profession must do its share to help solve the problem. Our first responsibility is to continue to strive for the highest quality of care possible through continuing medical education efforts; second, we must also develop effective quality assurance and risk management programs in light of rapid technological advances; and third, we must renew our scrutiny of licensing procedures. It is through these mechanisms that we can squarely meet the problem of medical care that does not meet current acceptable standards of the profession.

In addition, the medical profession must be allowed to develop mechanisms of dealing with the impaired or marginal physician who does not consistently practice quality medical care.

As I stated earlier, this is a complex problem and the members of the American Academy of Orthopaedic Surgeons are delighted that this committee is examining the crisis in professional and product liability insurance. It is only through working together that the public and the medical profession can end this costly crisis.

Mr. Chairman, thank you for this opportunity to testify before your committee and I will be happy to answer any questions.

Mr. ANTHONY. Harry S. Jonas, president-elect of American College of Obstetricians and Gynecologists.

STATEMENT OF HARRY S. JONAS, M.D., PRESIDENT-ELECT, AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

Dr. JONAS. I am Harry S. Jonas, M.D., an obstetrician/gynecologist and dean of the University of Missouri School of Medicine at Kansas City. I am president-elect of the American College of Obstetricians and Gynecologists [ACOG], an organization of more than 25,000 physicians specializing in the delivery of health care to women. I am pleased to have this opportunity to speak to you about an issue which is of overriding concern to physicians and particularly members of our specialty, and that is the cost and availability of professional liability insurance.

It has never been safer for a mother to have a baby in the United States than today. And it has never been more risky for a doctor to deliver one. We are seeing more and more physicians getting out of obstetrics because of the fear of lawsuits or because they are unwilling or unable to pass the costs of liability insurance on to their patients. In 1985, 12 percent of our fellows made that decision.

In some parts of the country, it is getting harder to find a doctor to deliver a baby. And, most unfortunately, the litigious climate today creates tension between patient and doctor, which does nothing to help the healing process.

The traditional professional liability system is breaking down. Not only have premiums shot up, they have doubled for obstetrician/gynecologists in the past 2 years.

In Broward and Dade Counties in Florida, obstetrician/gynecologists pay between $82,000 and $118,000 a year for their insurance. In Virginia, if they want to open a solo practice, they can't get insurance at any cost. In the past 13 months in my own home State of Missouri, there was a 207-percent increase in liability premiums.

I still take obstetrical cases, but since I work in a public hospital my policy is carried through the hospital. Our premium this year doubled, from $600,000 to $1.2 million, financed by the city of Kansas City. But our coverage dropped from $25 million to $2.5 million. In a hospital which serves the poor, premium increases of this type mean cuts in services to patients.

Three-quarters of all obstetrician/gynecologists have been sued at least once. This year, one out of six will be sued. And a typical obstetrician/gynecologist starting a 35-year career right now can expect to be sued eight times in his or her career.

If medical care was getting worse, these statistics would not be surprising; but all our indicators show better and better outcomes. Infant mortality is down. Maternal mortality is down. Lawsuits are up.

Malpractice does happen, and when it does the patient should be compensated promptly and fairly. Physician discipline efforts must be expanded at the State and local levels to protect the public. But it is impossible to believe that so many doctors are guilty of bad practices; and it is equally impossible to believe that the incredible increase in costs is justified. Especially, when only one-quarter of each malpractice premium dollar goes to the patient. The rest goes to the system.

ACOG is an organization dedicated to the continuing education of physicians. We are developing peer review and quality assurance programs, programs designed to look at the quality of care being rendered by physicians.

But the overall system is out of control, and we have to do something to stop this chaos. Tort reform at the State level has, in some States, helped to alleviate the problem. But that is not enough. We hope that you, in the Congress, can at the Federal level help develop long-range solutions so that the problem doesn't constantly recur. The time has come to look at alternative solutions before it is too late.

The ACOG is supporting H.R. 3084, introduced by Representatives Moore and Gephardt. This bill provides a comprehensive approach and promises to provide prompt payment to injured parties with significant reductions in the costs associated with settling claims.

We appreciate your efforts, Mr. Chairman, in addressing this issue and in recognizing that this is a national problem. It affects all parts of society. We look forward to working with you.

I would be delighted to answer any questions you may have.

[The prepared statement and attachments follow:]

STATEMENT
# of the
AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

Presented by

Harry S. Jonas, M.D.

Mr. Chairman and Members of the Subcommittee, I am Harry S. Jonas, M.D., an obstetrician/gynecologist and Dean of the University of Missouri School of Medicine at Kansas City. I am President-elect of the American College of Obstetricians and Gynecologists (ACOG), an organization of more than 25,000 physicians specializing in the delivery of health care to women. I am pleased to have this opportunity to speak to you about an issue which is of overriding concern to physicians and particularly members of our specialty, and that is the cost and availability of professional liability insurance coverage.

It has never been safer for a mother to have a baby in the United States than today. And it has never been more risky for a doctor to deliver one. Today we are seeing more and more physicians getting out of obstetrics because they are unable or unwilling to pass on the costs of liability insurance to their patients. We are seeing some patients paying more than $850 of their obstetric fee just for the cost of professional liability coverage. We are seeing doctors who want to set up practice who literally cannot get insurance at any price. We are seeing an increasing tension and growing distrust between patients and physicians. None of these developments can, in any way, be considered contributions to the healing process.

Today, obstetrician/gynecologists in Broward and Dade Counties in Florida pay $82,000 to $118,000 per year for professional liability insurance. In Virginia, obstetrician/gynecologists wanting to open a solo practice cannot insure themselves at any cost. In the last thirteen months, obstetrician/gynecologists in the state of Missouri have been faced with a 207% increase in liability premiums. One third of family doctors in California, whose practices had included obstetric services, no longer provide obstetric care. One half of family physicians in rural Nevada will have stopped delivering babies by April 1, 1986. In July of last year, the American College of Nurse-Midwives lost its malpractice insurance carrier. This problem affects family physicians who do obstetrics, certified nurse-midwives as well as board certified obstetrician/gynecologists, and threatens access to maternity care.

COST AND AVAILABILITY OF INSURANCE

The traditional professional liability insurance system is breaking down. Nationally, in the past two years, premiums for obstetrician/gynecologists have doubled. National statistics are fine, but they do not really tell the whole story. In 1985, premiums for $1 million worth of coverage ranged from a low of $6,200 in Arkansas to a high of $72,000 in New York. While all of the rate increases for 1986 are not available, we do know that premiums are going up dramatically. Rates in 1986 for the same $1 million worth of coverage are as high as $58,000 in Michigan, $41,800 in California, and $118,000 in Florida. Annual percentage rate increases have also been dramatic, including 65.3% in Colorado, 81% in Montana, & 88.1% in Utah.

The increasing cost of liability insurance to cover the provision of obstetrical care also affects other physicians and their patients. For example, in Mississippi, Missouri and Florida, family practitioners who do high-risk obstetrics or a threshold number of deliveries a year are charged the same amount for professional liability insurance as obstetricians.

And now, we are beginning to see situations where insurance is not available at any cost. As of the first of this year, the St. Paul Fire and Marine Insurance Company (St. Paul), the largest commercial carrier for medical malpractice insurance, imposed a nationwide moratorium on writing new business for medical malpractice insurance for all physicians. Although St. Paul indicates this moratorium is only temporary, that remains to be seen.

Virginia, until recently, had three malpractice carriers. The Virginia Reciprocal Company announced in the fall of 1985 that it would no longer accept applications from obstetrician/gynecologists. The second carrier, St. Paul, as previously discussed, placed a moratorium on writing new business. The third, PHICO, will only insure obstetrician/gynecologists in single or multi-specialty groups of five or more. Obstetrician/gynecologists who want to open up a solo practice or group practice of less than five, as 70 percent do, are unable to obtain any insurance, even though Virginia has enacted comprehensive tort reform measures, including an absolute $1 million cap on medical malpractice awards.

The crisis in obstetrics affects not only board certified obstetrician/gynecologists, but all reproductive health care providers. In 1985 both the American College of Nurse-Midwives and the ACOG had their nationally sponsored policies cancelled. Neither group has been able to locate a new source of group coverage and the American College of Nurse-Midwives has been forced to investigate the possibility of forming its own captive company.

FREQUENCY OF SUITS

Physicians face much more than escalating premiums and the loss of available insurance. They must consider the threat of a lawsuit with each patient they see which damages the patient/physician relationship. St. Paul reports that claims against physicians overall increased 107% between 1979 and 1984 and that the typical obstetrician/gynecologist starting a 35 year career at the present time can expect to be sued eight times. Before 1976, one out of twenty obstetrician/gynecologists were sued each year. This year one out of six will be sued.

73% of the Fellows surveyed by the ACOG in 1985 had at least one professional liability claim filed against them. There is an increasing number being sued more than once. For example, in 1985, 30% of Fellows had been sued three or more times. In New York and the Mid-Atlantic states (Pennsylvania, New Jersey and Delaware) almost half of the ACOG Fellows have been sued three or more times. If medical care were getting worse, the crisis in liability would not be surprising, but all indications show better and better outcomes. Infant mortality rates are down, maternal mortality rates are down, yet the number of lawsuits is increasing.

As the frequency of lawsuits has increased, so has the cost. There were 70 awards of a million dollars or more in the area of medical malpractice in 1983, compared with 4 in 1976. It is becoming commonplace for juries to award million dollar plus verdicts in medical malpractice cases.

ACCESS TO OBSTETRICAL CARE

In 1983, we reported that nationwide 9% of our Fellows had quit the practice of obstetrics due to the risk of malpractice; in 1985 that figure had risen to 12.3%. This is an increase of more than one third from 1983 to 1985. In Florida, one out of four of our physicians reported discontinuing obstetrics, almost twice the national average. This figure was confirmed by a 1985 Florida Medical Association survey.

One reason why many obstetrician/gynecologists are discontinuing the practice of obstetrics is the reduced premium for those who practice only gynecology. The current rate for physicians practicing only gynecology in Broward and Dade Counties in Florida is $51,800. In order to practice obstetrics, they will pay $118,000 or 127% more. Florida is just one example of the problem: obstetricians pay 97% more in Hawaii, 111% more in Maryland, 66% more in Montana and Utah, and 96% more in Idaho than their counterparts who practice only gynecology.

In the 1985 survey we took a closer look at those Fellows who have discontinued obstetrics due to the risk of professional liability. The age at which these physicians have discontinued obstetrics is one of the most ominous findings from the survey. Of those physicians who stopped practicing obstetrics, 25% gave it up before the age of 45 and 50% gave it up by the age of 55. It has traditionally been assumed that a typical obstetrician/gynecologist would phase out his obstetrical practice as his patient population aged and make a normal transition to a gynecologic practice around the age of 55. With more than half of our Fellows discontinuing obstetrics before that age for liability reasons, it is clear that we are losing some of our most experienced and competent practitioners.

Although recognizing it is unlikely there will ever be a shortage of physicians willing to practice obstetrics in urban areas such as Washington, D.C. or New York City, the same fact is not true for rural areas. Pregnant women in rural areas, such as Nevada, the island of Molokai or in Kohalo, Hawaii, are already experiencing physician shortages. These women are being forced to travel to metropolitan areas for prenatal care and delivery. Many of them may not be able to afford, in terms of money or time, to travel the necessary distance and will have no choice but to go without care.

ACOG EFFORTS

We know that the medical profession is not alone in grappling with the problems of liability. This is an issue which concerns bus companies, day care centers, municipalities and many other forms of public and private enterprise. As a society, all of us are affected by the cost and lack of availability of liability insurance through the higher prices we must pay for needed services and the unavailability of services previously enjoyed.

In an attempt to better understand the problem, the College was the first medical specialty society to establish a department of professional liability three years ago. That department, which currently employs a full time staff of six, serves principally as a resource to Fellows of the College and the public on professional liability issues. The resources include access to up-to-date professional liability insurance information, and educational materials on the legal system and risk management. In 1983 and 1985 the College conducted surveys (appended) of the membership to determine the effect of professional liability on the provision of obstetrical care. The department also works with other organizations, both medical and non-medical, to develop programs to alleviate the liability crisis. We have worked with attorneys and insurance carriers to better understand the dynamics between the quality of medical care rendered, the frequency of lawsuits, the size of awards or settlements, and the rate of increase in insurance premiums. There are some who attribute the problem to lawyers, or insurance companies, or bad doctors, or to public expectation of perfection. It is apparent that the liability crisis is not limited to medical liability; it has become a societal issue. We have learned there are no easy answers or simple explanations.

It is difficult to allege avarice on the part of insurance companies when more than 50% of physicians are insured by physician-owned companies whose premiums continue to escalate at the same rate as commercial carriers.

We cannot assume the problem to have arisen solely from contentious attorneys; however, the legal profession must accept its responsibility to be part of the solution.

With the amount of publicity given to "medical miracles," one can understand the public expectation of perfection. But perfection is an unrealistic goal in medical practice.

The "bad doctor" has been blamed for the current crisis. The fact that 73% of our Fellows surveyed have been sued indicates to us that virtually no one is immune from the threat of a lawsuit, no matter how well qualified or conscientious. State licensing boards hold the ultimate responsibility to discipline physicians, and must be encouraged to do so. There is no question that legislative help is needed to encourage and protect hospitals and the medical profession in their attempts to deal with the marginal practitioner.

One of our objectives is to improve constantly the quality of patient care. In this regard, the College has taken a number of concrete steps. We publish standards and guidelines for care, technical bulletins on specific subjects and procedures, and offer a quality assurance program for use by hospital departments. We provide a number of scientific meetings, 25-30 post-graduate courses, nine regional meetings and a national clinical meeting each year. A variety of printed and taped educational tools are also available. Additionally, our Department of Professional Liability distributes information to provide better risk management as well as up-to-date information about state law, case law, regulations and insurance activities.

The current system for compensating injured parties is time consuming, frequently resulting in delays of 2-5 years in receiving payment. It is also inefficient, with as little as 28% going to the injured party. We contend that a system which returns so little of the premium dollar to the injured party and which requires so much time for the settlement of disputes is unacceptable.

FEDERAL ROLE

The states have been active in trying to address this issue. In the area of tort reform, for example, most states have enacted changes in their laws over the past decade. In addition to the so-called traditional tort reforms, states have tried a number of more creative mechanisms and, as a result, patient compensation funds, joint underwriting associations, mediation panels and other such mechanisms came into being. Tort reform in the states is viewed by many as the preferred solution to the current liability crisis. But the fact is obvious that this helter skelter approach has not worked. Once again we have a liability crisis. Tort reforms have achieved only limited success at best.

For years, federal legislators have responded to the issue by stating that it is the states' role via tort law and insurance regulation to maintain a workable system for adjudicating the claims of injured parties and assuring adequate regulation of the insurance industry. We believe neither system is working well, and in fact the problems are national in scope.

The days are gone when each of the fifty states could individually deal with this problem. In the field of medicine, doctors are increasingly held to national standards of care. We believe it is time for national leadership to assert its role in addressing the tremendous liability problems facing the country.

CONCLUSION

For these reasons, the ACOG looks to the Congress to address this issue and to develop model solutions aimed at solving the recurrent liability insurance crisis faced by obstetrician/gynecologists which threatens access to high-quality maternity care for the women of this country. While we support such efforts as tort reform at the state level, quality assurance and risk management programs, increased physician discipline and improved medical research, we believe it is time to look at alternative methods in the areas of professional liability. For this reason, the ACOG has endorsed H.R. 3084, a bill pending before this Committee which was introduced by Representatives Moore and Gephardt. This bill provides a comprehensive approach to professional liability and holds promise to provide prompt payment to injured parties with a significant reduction in the costs associated with settling claims. By eliminating the necessity for physicians and patients to be adversaries, it will reduce the tension between them. We believe such an approach would lead to greater predictability for insurance carriers and reduce pressures for the escalation of premiums to cover unpredictable losses.

Mr. Chairman, we appreciate your efforts in looking into this problem and the leadership the Committee has shown in recognizing that the liability problems facing this country are national in scope, transcending state boundaries. We look forward to working with you in the future, and I would be delighted to answer any questions you may have.

PROFESSIONAL LIABILITY INSURANCE AND ITS EFFECT: REPORT OF A SURVEY OF ACOG'S MEMBERSHIP

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I. INTRODUCTION

A major concern of the American College of Obstetricians and Gynecologists (ACOG), as well as healthcare administrators and professionals involved in prenatal care and delivery, is the significant and increasing cost of medical liability insurance. Liability insurance for OB/GYNs ranks among the highest for any medical speciality and is known to be as much as $72,000 annually in some areas of the country (e.g., Long Island). ACOG is not only concerned with the impact of such insurance rates on their membership in terms of financial pressure, medical procedures and professional prestige, but also with the effect on patient medical costs and availability of care.

To examine the effects of the cost of liability insurance as well as the increased risk of being sued for malpractice, a cross-sectional mail survey was conducted of a stratified random sample of ACOG's membership in the summer of 1985. The survey formed the second stage of a two stage research effort designed to obtain valid, reliable information regarding these issues. The methodology involved in this effort is described in the following section.

2. METHODOLOGY

2.1 Questionnaire Construction

The first stage of the research effort consisted of 15 in-depth interviews with practicing OB/GYNs who had experience with a malpractice claim. These preliminary interviews were designed to identify the major issues related to professional liability and thus provide a firm foundation for developing the quantitative study. Physicians were interviewed in person in the Washington, D.C. area and by telephone in other regions of the country.

Some of the issues addressed in the in-depth interviews included the following:

- Basis for the origin of malpractice claims;
- Process involved in resolving claims; and
- Effect of malpractice claim on physician's practice.

The interview results were then analyzed and a draft questionnaire was developed with the cooperation of ACOG's Department of Professional Liability. The draft questionnaire was pre-tested among a small sample of ACOG Fellows throughout the country and minor modifications were made as necessary to increase the clarity and comprehensiveness of the instrument. The final questionnaire is presented in the Appendix.

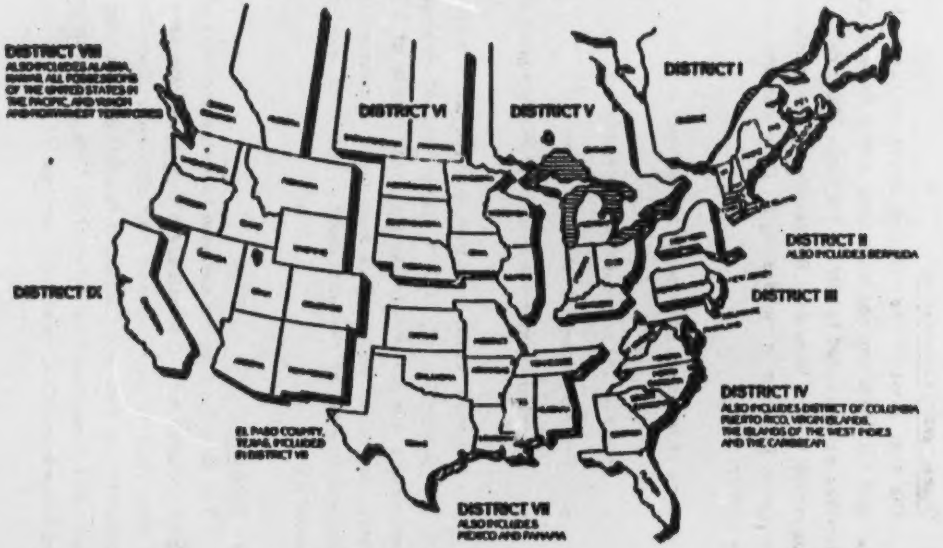
2.2 Sampling

The sampling plan was designed to ensure that nine of ACOG's districts (excluding District X (see Chart 1)) as well as the state of Florida were adequately represented so as to allow separate examination of their responses. Since Districts II and IX represent the states of New York and California, respectively, the plan thus permitted the detailed analysis of three important states: New York, California and Florida. A random sample was drawn from ACOG membership records.

Chart 1

THE NINE GEOGRAPHICAL DISTRICTS OF
The American College of Obstetricians and Gynecologists

Armed Forces District includes all Fellows on active duty in the Military Services or who, upon retirement, maintain membership in this District.


DISTRICT VIII
ALSO INCLUDES ALASKA, HAWAII, ALL POSSESSIONS OF THE UNITED STATES IN THE PACIFIC, AND YUKON AND NORTHWEST TERRITORIES
DISTRICT VI
DISTRICT V
DISTRICT I
DISTRICT II
ALSO INCLUDES BERMUDA
DISTRICT III
DISTRICT IX
DISTRICT IV
ALSO INCLUDES DISTRICT OF COLUMBIA PUERTO RICO, VIRGIN ISLANDS, THE ISLANDS OF THE WEST INDIES AND THE CARIBBEAN
EL PASO COUNTY, TEXAS, INCLUDED IN DISTRICT VIII
DISTRICT VII
ALSO INCLUDES MEXICO AND PANAMA

Four strata with variable sampling rates were created to assure that sample sizes would be sufficiently large for statistically reliable results in each ACOG district individually and in Florida. This required that areas with smaller populations be oversampled in the following manner within the four strata:

Region	Sampling Ratio
Florida	1 in 2
District I	1 in 3
District II (New York) District VI District VIII	1 in 4
Districts III, V, VII, IX District IV excluding Florida	1 in 5

This design yielded a sample of 4,143 physicians.

As mentioned, District X (composed of OB/GYNs in the military) was deleted from the sampling frame in order to match the sampling procedure of ACOG's 1983 study.* In addition, three other groups were deleted from the sampling frame: members outside of the 50 states, Junior Fellows still in residency, and inactive members. Junior Fellows in residence were eliminated as a function of their "term date" — all those with a term date of 1988 or beyond were deleted. Additional inactive practitioners (a total of 11.3% of the respondents) were deleted post hoc as a function of their self-identification in the survey responses.

Chart 2 gives the actual sample size and the response rate by region.

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* "Professional Liability Insurance and Its Effects: Report of a Survey of ACOG's Membership," August 31, 1983.

Chart 2

OVERALL NUMBER OF ACTUAL* RESPONDENTS AND RESPONSE RATES, BY GEOGRAPHIC DISTRICT

(unweighted)

		N	Response Rates
TOTAL		1,646**	39.7
I.	New England	125	35.3
II.	New York	151	36.7
III.	Mid Atlantic	118	35.4
IV.	Southeast Excluding Florida	215	43.2
V.	Great Lakes	152	42.2
VI.	Middle North	164	40.7
VII.	Middle South	201	37.3
VIII.	West	176	47.7
IX.	California	168	38.0
	Florida	173	39.9

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* Response rate totals include the following ineligible respondents:

- Junior Fellows still in residence;
- retired individuals;
- teaching only individuals; and
- individuals indicating "other" as their Type of Practice.

** Totals for geographic regions omit individuals who did not indicate in what state their practice is located.

2.2.1 Expected Sampling Error and Statistical Significance. The reason for pursuing the sampling and field procedures outlined in the previous sections was to produce an unbiased sample of the study population which would have the same properties and characteristics of the population from which it was drawn--subject, of course, to a certain level of sampling error, and subject to deliberately imposed restrictions on the population such as the desire in this case to be overly representative of Fellows as opposed to Junior Fellows. We can derive the maximum expected sampling error for a simple random probability sample from the following formula:

$$S\ (x) = z_{\alpha/2} \sqrt{\frac{p(q)}{n-1}} \quad \text{where:}$$

$S\ (x)$ = the expected sampling error of the mean of some variable, expressed as a proportion;

z = the standard normal score for some confidence limit;

p = some proportion of the sample displaying a certain characteristic or giving a certain answer on some variable or question;

q = 1.0 - p; and

n = the size of the sample.

Assuming a desired confidence level of 95%, for example, the formula can be solved for the maximum expected sampling error for various sample sizes or sample splits (e.g., geographic district).

We need only to perform some simple calculations in order to test whether or not a difference between two subsample proportions is statistically significant. We can obtain the sampling error of the difference between two selected samples by figuring:

$$S_d = \sqrt{S^2_1 + S^2_2} \quad \text{where:}$$

S_1 = the total sampling error of the first subsample;

S_2 = the total sampling error of the second subsample; and

S_d = the sampling error of the difference.

Any difference between observed proportions that exceeds S_d represents a significant difference.

The sampling error for response distributions of groups of different sizes is given in Chart 3, expressed as percentages. With a limited amount of interpolation and calculation, the statistical significance of differences observed in the majority of the following tables can be established fairly easily. Chart 4 presents the sample sizes used in the analyses upon which the estimates of statistical significance should be based. In viewing the tables presented, it is important to recognize that the percentages are based on numbers that have been weighted up to represent the survey population estimate rather than the actual sample response. It also should be noted that, since the estimates of pooled sampling error were calculated on a binomial distribution where $p = 0.5$, the values presented in Chart 3 should be viewed as indicating the maximum difference values required for giving statistically significant contrasts; this then provides the most conservative estimates of significance.

To ascertain whether the difference between any two proportions on a given table is significant, the following steps would be performed. For example, in order to examine the significance of the difference on Table 4: Predominant Type of Practice (examining regional differences in the fee for service, solo practice types), one would first calculate the difference between the desired regional responses (e.g., 55.1% (New York) - 31.4% (Mid North) = 23.7%). Next, find the actual sample size for both regions by referring to Chart 4 (e.g., 133 (New York) and 148 (Mid North)). Finally, using the actual sample sizes, refer to Chart 3 to determine how large a difference must be in order to reach statistical significance (e.g., given an initial sample size of approximately 150 and a second sample of approximately 150, a difference must exceed 11.4 percent in order to reach significance).

Chart 5 gives the expected sampling error for different percentage distributions within a single sample at a 95 percent confidence level. Thus, with a sample of 1,500 and a distribution where 90 percent of the respondents fall in one category (10% in the other category), the estimate provided by the sample is accurate within plus or minus 1.5 percent. With a more heterogeneous distribution (50-50) the estimate is expected to be accurate within plus or minus 2.5 percent.

Chart 3

PERCENTAGES WHICH INDICATE A STATISTICALLY SIGNIFICANT DIFFERENCE BETWEEN TWO SUBSAMPLES

(Assuming p=q, at 95% Confidence Level)

Size of Sample 2	Size of Sample 1						
	100	150	200	250	300	400	1200
100	13.9	12.7	12.1	11.6	11.4	11.0	10.2
150		11.4	10.6	10.2	9.8	9.4	8.5
200			9.8	9.3	9.0	8.5	7.5
250				8.8	8.4	7.9	6.8
300					8.0	7.4	6.3
400						6.9	5.7
1200							4.0

Chart 4

UNWEIGHTED SAMPLE SIZES FOR RELEVANT COMPARISONS
(Excluding ineligible respondents)

Region		Actual Sample Size*
I.	New England	111
II.	New York	133
III.	Mid Atlantic	105
IV.	Southeast Excluding Florida	196
V.	Great Lakes	138
VI.	Middle North	148
VII.	Middle South	183
VIII.	West	156
IX.	California	151
	Florida	137

*These totals omit individuals who did not indicate in what state their practice is located.

Chart 5

Expected Sampling Error (Plus or Minus) at 95% Confidence Level
(Simple Random Sample)

Size of Sample or Subsample	Percentage of the sample or subsample giving a certain response or displaying a certain characteristic for percentages near: 10 or 90	20 or 80	30 or 70	40 or 60	50
2500	1.2	1.6	1.8	1.9	2.0
2400	1.2	1.6	1.8	2.0	2.0
2300	1.2	1.6	1.8	2.0	2.0
2200	1.3	1.7	1.9	2.0	2.1
2100	1.3	1.7	2.0	2.1	2.1
2000	1.3	1.8	2.1	2.2	2.2
1900	1.3	1.8	2.1	2.2	2.2
1800	1.4	1.8	2.1	2.3	2.3
1700	1.4	1.9	2.2	2.3	2.4
1600	1.5	2.0	2.2	2.4	2.5
1500	1.5	2.0	2.3	2.5	2.5
1400	1.6	2.1	2.4	2.6	2.6
1300	1.6	2.2	2.5	2.7	2.7
1200	1.7	2.3	2.6	2.8	2.8
1100	1.8	2.4	2.7	2.9	3.0
1000	1.9	2.5	2.8	3.0	3.1
900	2.0	2.6	3.0	3.2	3.3
800	2.1	2.8	3.2	3.4	3.5
700	2.2	3.0	3.4	3.6	3.7
600	2.4	3.2	3.7	3.9	4.0
500	2.6	3.5	4.0	4.3	4.4
400	2.9	3.9	4.5	4.8	4.9
300	3.4	4.5	5.2	5.6	5.7
200	4.2	5.6	6.4	6.8	6.9
100	5.9	7.9	9.0	9.7	9.8
75	6.8	9.1	10.4	11.2	11.4
50	8.4	11.2	12.8	13.7	14.0

Note: Entries are expressed as percentage points (+ or -).

3. RESULTS

3.1 Physicians' Demographics

Tables 1 through 3 present respondents' demographic characteristics, including the following:

- Sex
- Age
- Number of years in practice

Sex and Age (Tables 1-2)

- The majority of respondents were male (93.0%). Geographically, females were relatively more highly represented in the New York region (12.8%) and were under represented in the West region (3.2%).

- Nearly 90 percent of all respondents were between 35 and 65 years of age. Respondent ages were evenly distributed among each of the middle age ranges; with 34.1 percent ages 35 through 44; 31.3 percent ages 45 through 54; and 24.3 percent ages 55 through 64 years old. Small proportions of younger (2.5% less than 35 years) and older (7.9% 65 years and older) physicians responded.

- The average age of respondents was 49.6 years. A few differences in ages were apparent across regions. OB/GYNs in New England and New York regions were more likely to be 55-64 years of age (29.7% and 33.1%, respectively vs. 24.3% overall). Physicians surveyed in the Mid South and West were more likely to be 35-44 years old (38.5% and 44.2%, respectively vs. 34.1% overall). In Florida, OB/GYNs were more likely to be between 45-54 years old (41.6% vs. 31.3% overall).

Years Practicing (Table 3)

- o Of all those OB/GYNs surveyed, 32.3 percent had been in practice 11-20 years, 24.8 percent had been in practice 21-30 years, and 23.2 percent had been practicing 6-10 years. Few OB/GYNs had been in practice for more than 30 years (12.5%) or for five or fewer years (7.2%).

- o Across all respondents, the mean number of years spent in practice was 18.1. Responses across regions indicated differences in the number of years they had been in practice. Consistent with the regional difference in age distribution, physicians in the New England and New York regions were more likely to have been in practice 21-30 years (30.6% and 32.3%, respectively vs. 24.8% overall). In addition, OB/GYNs in the Mid Atlantic region were also more likely to have been in practice 21-30 years (30.5%). Also consistent with the age distribution, doctors in the Mid South and West were more likely to have been in practice 6-10 years (29.1% and 29.5%, respectively vs. 23.2% overall).

3.2 Practice Description

Tables 4 through 10 present an analysis of the survey questions describing OB/GYN practices. Topics discussed in this section include the following:

- -- Predominant type of practice
- -- Gross income from medical practice
- -- Percent practicing obstetrics
- -- Physicians not practicing obstetrics
- -- Number of deliveries per month
- -- Percent of obstetrical practice devoted to high-risk care

Predominant Type of Practice (Table 4)

- o A total of 92.0 percent of all respondents reported being in a fee for service practice. Of these, 45.2 percent were in solo practice, 40.2 percent were in a single specialty partnership or group practice, and 6.6 percent were in a multispecialty group or partnership.

- Regional variations were apparent. Compared to a 45.2 percent overall rate of solo practices, New York (55.1%) and California (55.2%) were high, while the Mid North (31.4%) was low. The South East region was more likely to have single specialty groups and the California region was less likely (50.0% and 30.3%, respectively vs. 40.2% overall). The Mid North region had a relatively high percentage of multi-specialty groups represented (23.3% vs. 6.6% overall).

Gross Income from Medical Practice (Table 5)

- Of all OB/GYNs surveyed, the mean gross income from their medical practice in 1984 was $215,011. Overall, 34.2 percent of respondents reported gross incomes of $250,000 or more, 30.6 percent had gross incomes between $150,000 and $249,999, 21.4 percent indicated gross incomes between $100,000 and $149,999, and 13.8 percent reported gross incomes below $100,000.

- Regional analyses revealed that a higher percentage of physicians in the Mid South (44.0%), California (46.1%) and Florida (44.4%) had gross incomes of $250,000 or more (compared with 34.2% overall) while physicians in the South East (23.3%) were least likely to be in this category.

Percentage of Practice Devoted to Obstetrics (Table 6)

- The majority of respondents (68.3%) devote 50 percent or less of their practice to obstetrics. Overall, 45.1 percent of OB/GYNs reported that 26-50 percent of their practice was devoted to obstetrics, 26.8 percent devote 51-75 percent to obstetrics; 23.2 percent devote 25 or less percent of their practice to obstetrics. Only 4.8 percent said they practiced obstetrics more than 75 percent of their time.

- OB/GYNs in the South East region were more likely to devote between 26 and 50 percent of their practice to obstetrics (50.3%), while physicians in the Mid South and Florida were less likely to be in this category (38.0% and 37.8%, respectively vs. 45.1% overall). Physicians in New York (36.5% vs. 26.8% overall) were more likely to devote 51 to 75 percent of their practice to obstetrics, while OB/GYNs in the South East (18.6%) were less likely to do so.

Physicians Not Practicing Obstetrics (Tables 7-8)

- Of those physicians not practicing obstetrics, 6.8 percent of respondents reported never having practiced obstetrics. Physicians in the New York region (18.2%) were most likely to report never having practiced obstetrics. However, the majority of respondents who do not currently practice obstetrics (93.2%) reported stopping at some point during their career.

- More than half of the physicians who stopped practicing obstetrics did so before the age of 54. Few physicians (2.8%) stopped practicing obstetrics before age 35 and 84.9 percent stopped their obstetrical practice before reaching age 65.

- Regional differences were observed in the age at which physicians stopped practicing obstetrics. Compared with the overall mean of 22.5 percent physicians in New England, Florida and the Mid South were more likely to stop between ages 35 and 44 (42.9%, 40.9%, and 33.3%, respectively). Respondents from the South East, Mid North and Mid South regions were more likely to stop between ages 45 and 54 (47.6%, 40.0%, 38.1%, respectively vs. 28.9%), while physicians in the Great Lakes and California regions were more likely to stop obstetrics between the ages of 55 and 64 (50.0% and 44.4% compared with 30.7%, overall). Of the 15.1 percent overall who stopped obstetrics after the age of 65, respondents in New York and California were more likely to stop at this age (33.3% and 27.8%, respectively).

- Other regional differences showed that physicians in several regions were less likely than the average to stop obstetrics at particular ages. OB/GYNs in the Great Lakes (7.1%), Mid North (10.0%) and California (11.1%) were less likely to stop between ages 35 and 44. New York physicians (11.1%) were less likely to stop between ages 45 and 54, while those in New England (7.1%) were less likely to stop obstetrics between the ages of 55 and 64. Additionally, few respondents in the Mid South (4.8%) reported stopping after the age of 65.

Average Number of Deliveries Performed Per Month (Table 9)

- o Of those who performed deliveries, respondents varied considerably in the average number of obstetrical deliveries that they perform. While over one third (36.5%) of all respondents delivered on average of between 8-12 babies per month, 25.2 percent delivered 13-19 babies a month, 20.8 percent delivered 1-7 babies per month and 17.5 percent reported delivering 20 or more babies per month.

- o Physicians in New York and the South East delivered fewer babies than any other regions with 34.5 percent and 28.5 percent, respectively, delivering 1-7 babies. Respondents in the Mid Atlantic and Great Lakes regions were more likely to perform 13-19 deliveries per month (30.2% and 31.6%, respectively). Respondents in the Mid South and West were more likely to perform the highest numbers (20 or more) of deliveries per month (24.8% and 24.6%, respectively).

Percentage of Obstetrical Practice Devoted to High Risk Care (Table 10)

- o Of all physicians who practice obstetrics, 50.1 percent devote 11-20 percent of their obstetrics practice to high-risk care. One quarter of these physicians devote 21-30 percent of their obstetrical practice to high-risk care while nearly another quarter (23.2%) devote 30 percent or more of their obstetrical practice to high-risk care.

- o Regional variations revealed that respondents in the Mid Atlantic (60.5%) region were most likely to spend between 11 and 20 percent of their time on high-risk obstetrical care. Physicians in New England (35.6%) were relatively more likely to spend between 21 and 30 percent of their time in this high-risk area.

3.3 Professional Liability Insurance

Tables 11 through 16 present OB/GYNs responses to questions concerning their primary coverage and expenses of professional liability insurance. Professional liability insurance is discussed in reference to:

- Coverage by professional liability insurance
- Cost of primary insurance coverage in 1984
- Comparison of the 1984 annual costs of primary coverage to those reported in the 1983 survey
- Reported annual premium increase since 1983 and comparison with the 1983 survey responses for the previous two year increase
- Cost of primary coverage relative to gross income

Coverage by Professional Liability Insurance (Tables 11-12)

- Of all OB/GYNs surveyed, 98.1 percent reported being covered by professional liability insurance. This response was consistent across regions with one exception. Physicians from Florida were more likely (8.0%) to be without professional liability insurance.

- Of all respondents who are covered by professional liability insurance, over half (52.4%) have primary coverage per claim of between $500,001 and $1,000,000. Nearly one quarter of OB/GYNs (23.2%) had primary coverage under $250,000. One-tenth of those surveyed had primary coverage per claim ranging from $250,001 to $500,000 (10.1%) while another 10.9 percent were covered from $1,000,001 to $3,000,000. Only 3.4 percent of respondents had coverage exceeding $3,000,000 per claim.

- Respondents from different regions varied in their limits of primary coverage per claim. Physicians in the Great Lakes and Mid Atlantic regions were more likely than the average (23.2%) to report having the lowest level of primary coverage 72.3 percent and 47.8 percent, respectively, while very few physicians in New York (2.5%), New England (5.2%), California (5.8%) and the West (8.2%) reported under $250,000 in primary coverage per claim. More respondents in Florida (31.6%) than in any other region (10.1% overall) reported primary coverage in the $250,001 - $500,000 range. Physicians from

New York (90.0% vs. 52.4% overall) were most likely to have primary coverage per claim of $500,001 - $1,000,000. OB/GYNs in the West (36.6%) and South East (27.6%) were most likely to have primary coverage greater than $1,000,000 per claim.

Cost of Primary Insurance Coverage in 1984 (Tables 13)

- o The expenses of OB/GYNs liability insurance in 1984 varied. Overall, respondents paid an average of $20,818 for primary insurance coverage, with 59.1 percent of all OB/GYNs paying between $8,000 - $24,999.

- o There were variations across regions in the costs of primary coverage in 1984. Respondents in the Great Lakes and Mid South regions were more likely to pay less than $15,000 (74.8% and 76.8%, respectively vs. 42.3% overall). Mid Atlantic physicians were most likely to have primary insurance expenses between $15,000 and $24,999 (66.7% vs. 30.6% overall).

  More respondents in New York (77.6% vs. 27.1% overall) and Florida (68.0%) paid over $25,000 for their primary coverage.

Comparison of 1984 Annual Costs of Primary Coverage to Those Reported in the 1983 Survey

- o The annual cost of primary coverage in 1984, reported in the present study, was compared to the annual cost of coverage reported in the 1983 survey. This comparison revealed a substantial rise in the annual cost of primary coverage. While 66.3 percent of the 1983 physicians reported primary insurance expenses under $15,000, only 42.3 percent of 1985 respondents indicated expenses under $15,000. In 1983, 9.4 percent of all respondents paid more than $25,000, while in 1985, 27.1 percent of the respondents had annual primary coverage expenses at this level. Across all regions, the proportion of physicians paying more than $25,000 for their primary insurance coverage increased from the 1983 survey to the current study, with the most dramatic increases seen in Florida (12.6% vs. 68.0%), New York (36.7% vs. 77.6%), California (21.8% vs. 48.5%), the West (2.8% vs. 24.8%), and the Mid North (12.2% vs. 33.6%).

Reported Annual Premium Increases Since 1983 (Tables 14-15)

o When directly asked, 92.8 percent of all respondents in the 1985 survey replied that their annual premium has increased since 1983. In contrast, 61.9 percent of physicians queried in 1983 reported having their annual premiums increased during the previous two years. In the 1983 survey, Florida (84.6%) and New York (81.9%) had greater proportions of respondents reporting an increase while those in the Great Lakes (45.8%) and Mid South (44.9%) were least likely to report an increase. In 1985, respondents in the Mid North (98.6%) were most likely to report an increase, while OB/GYNs in California (85.0%) and the Mid South (85.8%) were least likely to do so. However, the percentages reporting increases in California and the Mid South were higher than those in Florida and New York in 1983.

o Overall, respondents to the 1985 study reporting increases said that premiums had risen an average of $9,871 since 1983. OB/GYNs responding to the 1983 survey indicated this mean increase to be $4,607 over the previous two years.

o The increases in premiums reported by 1985 respondents were as follows: 31.4 percent reported increases of $4,000 - $7,999, 23.4 percent said their premiums rose $8,000 - $12,999, 23.9 percent indicated increases of $13,000 or more, and 21.4 percent reported increases less than $4,000.

o Regional analysis of the 1985 study shows that New York, Florida and the Mid North had the highest increases in annual premiums where increases occurred. New York OB/GYNs premiums rose an average of $21,635, Florida's premiums increased an average of $17,131, while premiums in the Mid North rose an average of $13,361. Premiums in the Mid South rose least with an average of $5,199. In comparison, the 1983 data also showed the highest mean increases to be in New York ($8,538) and Florida ($8,115).

o Of those reporting increases, respondents in the Great Lakes (40.7%) and Mid South (38.6%) regions were more likely to report smaller increases (less than $4,000). In contrast, physicians in New York (66.7%), Florida (52.3%) and the Mid North (43.6%) were more likely to report increases of $13,000 or more.

Cost of Primary Coverage Relative to Gross Income (Table 16)

- Mean values for the cost of primary coverage for respondents who are covered by liability insurance were divided by the mean values of gross income for respondents in each region. This calculated percentage, the expense of primary coverage as a percent of gross income, was 9.7 percent overall. While this percentage was generally consistent across most regions, New York (16.3%) and Florida (12.1%) had the highest percentages.

3.4 Professional Liability Claims Experience

Tables 17 through 30 discuss OB/GYNs responses to questions concerning their professional liability claims experiences. These experiences are reported in reference to the following:

- Number of professional liability claims filed against physicians
- Primary bases of malpractice claims
- Length of time between incident and filing of claim
- Experience with completed professional liability claims
- Status of insurance claim
- Length of time between filing and settling of the claim
- Amount paid on physician's behalf to settle claim
- Length of time between filing of claim and outcome of contested case
- Outcome of contested cases
- Malpractice suits increasing specific activities in practice
- Changes in practice as a result of malpractice
- Increases in professional fees resulting from increases in malpractice premiums

Number of Professional Liability Claims Filed Against Physicians (Table 17-18)

- Overall, 73.0 percent indicated that they had had at least one professional liability claim filed against them. A relatively higher percentage of physicians in the Mid Atlantic (86.7%), New England (82.7%) and New York (81.2%) regions indicated they had had at least one liability claim, while a relatively lower percentage of physicians in the South East (64.9%), California (65.6%), and the Mid South (67.0%) regions reported having at least one claim experience.

- Overall, 24.5 percent of respondents had had one claim, 19.5 percent had two claims and 28.5 percent had three or more claims filed against them. Regional variations revealed that physicians from New York (48.5%) and the Mid Atlantic (46.6%) regions were more likely to have had three or more claims filed against them.

- Comparison of these data with responses from ACOG's 1983 survey reveals a general rise in the number of claims filed against OB/GYNs, with 48.0 percent vs. 35.9 percent having faced two or more claims for 1985 and 1983, respectively.

Primary Bases of Malpractice Claims (Table 19)

- Of the primary allegations listed by physicians who had professional liability claims filed against them, gynecological patient injury was the basis for the largest single percentage (23.9%) of all malpractice claims filed. There was little regional variation in the percentages which fell into this category. Brain damage or injury to the infant accounted for 20.4 percent of the malpractice claims, with physicians in New York (30.2%) more likely to face this type of claim than any other region.

Length of Time between Incident and Filing of Claim (Table 20)

- One third of physicians (33.1%) reported a time lapse of one to three years between the incident in question and the filing of the claim, 19.1 percent indicated that between six and twelve months had passed and 10.4 percent indicated that less than six months had elapsed. Nearly as many, 9.2 percent, reported that more than three years between the incident and the filing of the claim elapsed.

- Compared to the overall (33.1%), Mid Atlantic (49.5%) and Florida (44.3%) OB/GYNs were more likely to report one to three years passing between the incident and filing of the claim. California's physicians (41.4%) were more likely than the 29.5 percent overall to have less than one year elapse between incident and filing.

Experience with Completed Professional Liability Claims (Table 21)

- Of all OB/GYNs who had claims filed against them, 71.1 percent reported having experience with completed claims. Respondents in California (83.3%) and the Mid Atlantic (82.0%) regions were particularly likely to report having completed such an experience. In contrast, New York physicians (57.7%) were least likely to have completed professional liability claims. Physicians who had experienced completed professional liability claims were asked to provide specific details related to the completed claim they considered most serious or significant. Tables 22 to 26 refer to this claim.

Status of Insurance Claim (Table 22)

- Of those respondents who had experienced completed liability claims, 71.4 percent settled the cases. The proportion of contested cases was highest in Florida (38.2%), the South East (37.9%) and Mid South (33.7%), compared with 28.6 percent contested overall.

Length of Time Between Filing and Settling of the Claim (Table 23)

- The majority of claims (69.3%) took at least one year to settle. Claims in New York took longer to settle than in other regions.

Amount Paid on Physician's Behalf to Settle Claim (Table 24)

- Among physicians who settled the claim, the median sum paid to settle claims was $30,000 while the mean amount was $178,567. Overall, 12.9 percent paid less than $5,000, while half the respondents who settled a claim (51.3%) settled for between $5,000 and $99,999. One fifth (20.0%) had $100,000 to $999,999, and only 4.6 percent had over $1,000,000 paid on their behalf. The remaining 11.1 percent paid nothing in order to settle the claim.

- Physicians in New England (37.5%) and Florida (29.3%) were more likely to settle the claim for higher amounts ($100,000 to $999,999) while those in the South East (18.4%) were most likely to settle without payment.

Length of Time Between Filing of Claim and Outcome of Contested Case (Table 25)

- For those respondents whose liability cases were contested, 44.4 percent overall said that two to five years elapsed between the time the claim was filed and the outcome was reached, while another 25.6 percent said that the elapsed time was between one and two years. The length of time between filing and outcome of contested cases was longest in the New York and California regions (84.6% and 84.2% of respondents, respectively, indicated that it took more than two years). In contrast, respondents in the South East and New England regions were most likely to indicate a shorter length of time between filing and outcome. In both regions, 33.3 percent of the respondents said the duration between contested claim filing and outcome was less than one year, compared to 19.3 percent of respondents overall.

Outcome of Contested Cases (Table 26)

- Of those respondents whose cases were contested in court, 80.9 percent reported that they won the case. These percentages were lower in New York (61.5%) and the Mid Atlantic region (71.4%)

- The dollar amount paid on behalf of those respondents who lost contested cases is not reported in this study, because most respondents settle cases or win contested cases so that the respondent base for this category is too small to provide a sound statistical basis for meaningful conclusions about trends.

Malpractice Suits Increasing Specific Activities in Practice (Table 27)

- Overall, a high percentage of physicians reported having increased the frequency with which they performed a number of activities as a result of their liability claims experiences. About two-thirds said they more frequently explained potential risks of recommended procedures, documented other activities such as office visits and phone calls, and performed more testing and diagnostic procedures (64.4%, 68.2%, and 67.8%, respectively). Increases in the frequency of monitoring procedures (58.8%), the provision of taped or written information to patients (49.1%), consultations with other physicians (44.2%) and obtaining written informed consent (43.1%) were also reported.

- Although the extent of reported increases in these activities was generally consistent across regions, there was some regional variation. Compared to respondents overall, California physicians were more likely to report that they more frequently provided written or taped information to patients (59.0%), obtained written informed consent (61.5%), and explained potential risks of recommended procedures (74.4%). New York physicians were more likely than respondents overall to indicate that they have increased the number of referrals to other physicians (50.0%) along with testing, and diagnostic procedures (77.6%). Physicians in the Mid North region were less likely than respondents overall to report an increase in physician referrals (25.7%) or an increase in obtaining written informed consent (31.1%).

Changes in Practice as a Result of Risk of Malpractice (Tables 28)

- Since the 1983 survey the percentage of respondents overall, who have made no changes in their personal practice as a result of the risk of malpractice has decreased from 68.2 percent to 62.9 percent. Comparing the 1983 and present survey, the overall percentage of respondents indicating decreases in their level of high risk obstetrical care increased from 17.7 percent to 23.1 percent. The percentage indicating decreases in the number of deliveries they perform increased from 10.1 percent to 13.7 percent, and the percentage indicating that they no longer practice obstetrics increased from 9.1 percent to 12.3 percent.

- Regional variations revealed the percentage reporting "no changes" dropped from 63.0 percent in 1983 to 55.9 percent in 1985 in New York, from 72.0 percent to 59.4 percent in the Mid Atlantic, from 77.3 percent to 65.9 percent in the South East, 69.3 percent to 53.5 percent in the Great Lakes, and from 52.7 percent to 44.1 percent in Florida. Contrary to this overall trend, the percentage of respondents indicating no practice changes increased in the New England region from 53.9 percent in 1983 to 71.8 percent in 1985.

- Physicians who indicated that they had done at least one of the following: decreased the number of deliveries, decreased the level of high risk obstetrics care or no longer practice obstetrics were combined together to determine the percentage of OB/GYNs who had made a significant change in their obstetrical practice. Compared with 35.0 percent overall, OB/GYNs in Florida (53.3%) and in the Great Lakes region (44.9%) reported making any changes in their obstetrical practice in much higher proportions, while fewer physicians from the New England region (25.3%) reported making any of these changes.

Increase in Professional Fees Resulting from Increase in Malpractice Premiums (Tables 29-30)

- Overall, the vast majority (82.9%) of physicians reported that the increase in the cost of malpractice insurance had directly affected their professional fees. There was some regional variation, however: Whereas 94.7 percent and 93.8 percent of physicians in the Florida and New York regions, respectively, said that their fees had been directly affected by malpractice insurance costs, relatively fewer physicians in the Great Lakes and Mid South regions reported that their fees had been directly affected by insurance costs (73.0% and 71.7%, respectively).

- For those respondents who indicated their fees had increased due to increases in malpractice premiums since 1983, the most commonly reported increases were between 6-10 percent (28.3%) and 11-15 percent (21.7%). Although the pattern of percentage increases in fees was generally consistent across regions, physicians in the New York region more frequently reported higher percentage increases.

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TABLE 1: SEX OF RESPONDENT

		REGION									
	TOTAL	New Eng.	New York	Mid Atl.	So. East	Grt Lks.	Mid Wo.	Mid So.	West	Ca.	Fla.
Male	93.0	92.8	87.2	91.4	93.4	94.9	91.2	96.2	96.8	92.0	91.2
Female	7.0	7.2	12.8	8.6	6.6	5.1	8.8	3.8	3.2	8.0	8.8

TABLE 2: AGE OF RESPONDENT

		REGION									
	TOTAL	New Eng.	New York	Mid Atl.	So. East	Grt Lks.	Mid Wo.	Mid So.	West	Ca.	Fla.
Less than 35	2.5	4.5	1.5	2.9	3.1	4.3	0.7	3.3	2.6	0.0	2.9
35 to 44	34.1	34.2	27.8	28.6	32.7	34.1	32.4	38.5	44.2	33.1	34.3
45 to 54	31.3	25.2	28.6	32.4	30.6	27.5	33.1	31.9	26.3	36.4	41.6
55 to 64	24.3	29.7	33.1	23.8	27.0	23.9	28.4	20.9	21.8	19.9	14.6
65 or over	7.9	6.3	9.0	12.4	6.6	10.1	5.4	5.5	5.1	10.6	6.6
Mean	49.6	49.3	51.1	51.2	49.8	49.8	50.1	48.3	48.1	50.1	47.9

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TABLE 3: YEARS SPENT IN PRACTICE

		REGION									
	TOTAL	New Eng.	New York	Mid Atl.	So. East	Grt Lks.	Mid No.	Mid So.	West	Ca.	Fla.
0-5	7.2	7.2	9.8	8.6	7.3	6.6	4.7	6.6	7.7	6.0	10.3
6-10	23.2	21.6	18.0	19.0	20.7	23.4	21.6	29.1	29.5	24.0	20.6
11-20	32.3	30.6	30.1	24.8	36.8	31.4	33.8	34.6	29.5	31.3	41.2
21-30	24.8	30.6	32.3	30.5	22.8	22.6	27.7	17.6	23.1	26.0	19.1
Over 30	12.5	9.9	9.8	17.1	12.4	16.1	12.2	12.1	10.3	12.7	8.8
Mean	18.1	18.4	18.6	19.9	18.2	18.7	18.6	17.0	16.4	18.4	16.4

TABLE 4: PREDOMINANT TYPE OF PRACTICE

		Region									
	TOTAL	New Eng.	New York	Mid Atl.	So. East	Grt Lks.	Mid No.	Mid So.	West	Ca.	Fla.
Fee for service solo practice	45.2	46.3	55.1	45.5	40.7	44.1	31.4	39.7	48.9	55.2	48.1
Fee/service, specialty group	40.2	34.7	34.7	45.5	50.0	44.1	38.0	42.9	36.6	30.3	41.2
Fee/service, multi-specialty group	6.6	6.3	3.4	2.0	1.1	5.5	23.3	8.1	9.0	3.4	7.6
Salaried employee or other	8.0	12.7	6.8	7.0	8.2	6.3	7.3	9.3	5.5	11.3	3.1

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TABLE 5: GROSS INCOME FROM MEDICAL PRACTICE

		REGION									
	TOTAL	New Eng.	New York	Mid Atl.	So. East	Grt Lke.	Mid No.	Mid So.	West	Ca.	Fla.
Less than $100,000	13.8	15.5	17.9	16.5	18.2	11.8	9.2	13.3	15.1	9.2	12.9
$100,000-$149,999	21.4	27.8	12.8	26.4	26.7	25.2	27.0	15.7	21.2	17.7	16.9
$150,000-$249,999	30.6	28.9	34.2	29.7	31.8	33.1	35.5	27.1	32.9	27.0	25.8
$250,000 or more	34.2	27.8	35.0	27.5	23.3	29.9	28.4	44.0	30.8	46.1	44.4
Mean	215011	196228	233547	202649	189553	200445	207020	223428	203740	243794	253736

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TABLE 6: PERCENTAGE OF PRACTICE DEVOTED TO OBSTETRICS

		REGION									
	TOTAL	New Eng.	New York	Mid Atl.	So. East	Grt Lks.	Mid No.	Mid So.	West	Ca.	Fla.
25 percent or less	23.2	25.3	19.0	24.5	25.7	19.0	20.0	27.0	17.4	24.4	32.3
26-50 percent	45.1	48.5	42.1	45.1	50.3	44.7	47.6	38.0	52.0	45.9	37.8
51-75 percent	26.0	21.4	36.5	26.5	18.6	31.1	29.7	29.8	25.3	23.6	23.6
76-100 percent	4.8	4.9	2.4	3.9	5.5	5.3	2.8	5.3	5.3	6.1	6.3

TABLE 7: PHYSICIANS NOT PRACTICING OBSTETRICS

Subsample: Respondents who do not practice obstetrics

		REGION									
	TOTAL	New Eng.	New York	Mid Atl.	So. East	Grt Lks.	Mid No.	Mid So.	West	Ca.	Fla.
Never practiced	6.8	0.0	18.2	0.0	12.5	6.7	9.1	4.5	0.0	10.0	8.3
Stopped during career	93.2	100.0	81.8	100.0	87.5	93.3	90.9	95.5	100.0	90.0	91.7

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TABLE 8: AGE AT WHICH PHYSICIANS STOPPED PRACTICING OBSTETRICS

Subsample: Respondents who stopped practicing obstetrics during career

		REGION									
	TOTAL	New Eng.	New York	Mid Atl.	So. East	Grt Lks.	Mid Wo.	Mid So.	West	Ca.	Fla.
Before age 35	2.8	7.1	0.0	6.3	0.0	0.0	0.0	4.8	0.0	0.0	9.1
Between 35 and 44	22.5	42.9	22.2	18.8	19.0	7.1	10.0	33.3	25.0	11.1	40.9
Between 45 and 54	28.9	28.6	11.1	18.8	47.6	35.7	40.0	38.1	31.3	16.7	13.6
Between 55 and 64	30.7	7.1	33.3	37.5	23.8	50.0	40.0	19.0	25.0	44.4	22.7
Age 65+	15.1	14.3	33.3	18.8	9.5	7.1	10.0	4.8	18.8	27.8	13.6

TABLE 9: AVERAGE NUMBER OF DELIVERIES PERFORMED PER MONTH

Subsample: Physicians who deliver babies

		REGION									
	TOTAL	New Eng.	New York	Mid Atl.	So. East	Grt Lks.	Mid Wo.	Mid So.	West	Ca.	Fla.
1-7	20.8	18.2	34.5	17.4	28.5	14.5	19.5	13.1	19.4	24.0	18.4
8-12	36.5	34.1	39.8	33.7	38.4	32.5	35.3	37.9	30.6	40.0	41.8
13-19	25.2	28.4	18.6	30.2	24.5	31.6	22.6	24.1	25.4	23.2	25.5
20 or more	17.5	19.3	7.1	18.6	8.6	21.4	22.6	24.8	24.6	12.8	14.3

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TABLE 10: PERCENTAGE OF OBSTETRICAL PRACTICE DEVOTED TO HIGH-RISK CARE

Subsample: Physicians who practice obstetrics

		REGION									
	TOTAL	New Eng.	New York	Mid Atl.	So. East	Grt Lks.	Mid Mo.	Mid So.	West	Ca.	Fla.
10 percent or less	1.6	2.3	0.9	0.0	1.9	0.0	0.8	3.4	0.8	2.4	4.0
11-20 percent	50.1	39.1	47.4	60.5	51.6	53.8	51.5	46.6	46.6	50.0	50.0
21-30 percent	25.1	35.6	26.3	19.8	25.5	23.9	25.0	21.9	29.0	25.8	24.0
30 percent or more	23.2	23.0	25.4	19.8	21.0	22.2	22.7	28.1	23.7	21.8	22.0

TABLE 11: COVERAGE BY PROFESSIONAL LIABILITY INSURANCE

		REGION									
	TOTAL	New Eng.	New York	Mid Atl.	So. East	Grt Lks.	Mid Mo.	Mid So.	West	Ca.	Fla.
Yes	98.1	100.0	100.0	99.0	99.0	98.5	98.6	97.8	98.1	96.0	92.0
No	1.9	0.0	0.0	1.0	1.0	1.5	1.4	2.2	1.9	4.0	8.0

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TABLE 12: LIMITS OF PRIMARY COVERAGE PER CLAIM

Subsample: Respondents covered by liability insurance

		REGION									
	TOTAL	New Eng.	New York	Mid Atl.	So. East	Grt Lks.	Mid No.	Mid So.	West	Ca.	Fla.
Under $250,000	23.2	5.2	2.5	47.8	14.9	72.3	25.6	24.2	8.2	5.8	16.2
$250,001-$500,000	10.1	10.4	3.3	6.5	4.0	10.1	9.6	13.0	6.0	15.7	31.6
$500,001-$1,000,000	52.4	66.7	90.0	38.0	53.4	15.1	50.4	47.8	49.3	68.6	48.7
$1,000,001-$3,000,000	10.9	12.5	4.2	7.6	20.7	1.7	8.8	11.8	27.6	7.4	3.4
Over $3,000,000	3.4	5.2	0.0	0.0	6.5	0.8	5.6	3.1	9.0	2.5	0.0

TABLE 13: COST OF PRIMARY INSURANCE COVERAGE IN 1984

Subsample: Respondents who are covered by liability insurance

		REGION									
	TOTAL	New Eng.	New York	Mid Atl.	So. East	Grt Lks.	Mid No.	Mid So.	West	Ca.	Fla.
Less than $8,000	13.8	6.0	3.2	6.1	19.9	27.6	14.2	26.2	6.6	6.3	[illegible].6
$8,000-$14,999	28.5	34.0	3.2	12.1	33.7	47.2	21.6	50.6	31.4	21.9	7.4
$15,000-$24,999	30.6	42.0	16.0	66.7	35.4	21.3	30.6	20.0	37.2	23.4	18.0
$25,000-$34,999	15.2	11.0	24.0	11.1	6.1	2.4	17.9	2.5	20.4	35.2	39.3
$35,000 or more	11.9	7.0	53.6	4.0	5.0	1.6	15.7	0.6	4.4	13.3	28.7
Mean	20818	19836	38153	19429	16046	11949	23025	16507	18353	22756	30805

ACOG2

TABLE 14: HAS ANNUAL PREMIUM INCREASED SINCE 1983

Subsample: Respondents covered by liability insurance

		REGION									
	TOTAL	New Eng.	New York	Mid Atl.	So. East	Grt Lks.	Mid No.	Mid So.	West	Ca.	Fla.
Yes	92.8	94.3	97.6	97.0	96.2	91.5	98.6	85.8	94.4	85.0	96.0
No	7.2	5.7	2.4	3.0	3.8	8.5	1.4	14.2	5.6	15.0	4.0

TABLE 15: AMOUNT THAT ANNUAL PREMIUM HAS INCREASED SINCE 1983

Subsample: Respondents whose annual premiums have increased

		REGION									
	TOTAL	New Eng.	New York	Mid Atl.	So. East	Grt Lks.	Mid No.	Mid So.	West	Ca.	Fla.
Less than $4,000	21.4	12.7	6.0	17.6	26.1	40.7	13.9	38.6	14.0	16.3	2.3
$4,000-$7,999	31.4	49.3	7.1	48.6	28.2	29.7	19.8	39.5	38.6	33.7	8.0
$8,000-$12,999	23.4	25.4	20.2	23.0	19.0	14.3	22.8	16.7	26.3	39.1	37.5
$13,000 or more	23.9	12.7	66.7	10.8	26.8	15.4	43.6	5.3	21.1	10.9	52.3
Mean	9871	7753	21635	7091	9380	7418	13361	5199	9056	7922	17131

ACOG2

TABLE 16: COSTS OF PRIMARY COVERAGE AS PERCENTAGE OF GROSS INCOME

Subsample: Respondents covered by liability insurance

		Region									
	TOTAL	New Eng.	New York	Mid Atl.	So. East	Grt Lks.	Mid Mo.	Mid So.	West	Ca.	Fla.
Mean gross income*	215011	196228	233547	202649	189553	200445	207020	223428	203740	243794	253736
Mean cost of primary coverage	20818	19836	38153	19429	16046	11949	23025	16507	18353	22756	30805
Percentage of gross income	9.7	10.1	16.3	9.6	8.5	6.0	11.1	7.4	9.0	9.3	12.1

*Based on entire sample

ACOG2

TABLE 17: HAS PROFESSIONAL LIABILITY CLAIM EVER BEEN FILED

		REGION									
	TOTAL	New Eng.	New York	Mid Atl.	So. East	Grt Lks.	Mid No.	Mid So.	West	Ca.	Fla.
Yes	73.0	82.7	81.2	86.7	64.9	77.4	74.3	67.0	68.6	65.6	72.9
No	27.0	17.3	18.8	13.3	35.1	22.6	25.7	33.0	31.4	34.4	27.1

TABLE 18: NUMBER OF CLAIMS FILED

		REGION									
	TOTAL	New Eng.	New York	Mid Atl.	So. East	Grt Lks.	Mid No.	Mid So.	West	Ca.	Fla.
Zero	27.4	17.3	20.0	13.6	35.1	22.8	25.7	33.1	32.0	35.3	27.3
1 claim	24.5	30.9	14.6	26.2	33.5	24.3	20.3	28.2	30.1	13.3	25.8
2 claims	19.5	26.4	16.9	13.6	16.0	18.4	21.6	23.2	20.9	19.3	22.0
3 or more claims	28.5	25.5	48.5	46.6	15.5	34.6	32.4	15.5	17.0	32.0	25.0

TABLE 19: PRIMARY ALLEGATIONS OF MALPRACTICE CLAIMS -- PERCENT OF TOTAL CLAIMS FILED

Subsample: Respondents who have experienced liability claims

	Region										
	TOTAL	New Eng.	New York	Mid Atl.	So. East	Grt Lks.	Mid Mo.	Mid So.	West	Ca.	Fla.
Brain damage/injury to infant	20.4	21.6	30.2	18.0	16.6	21.1	19.9	21.6	13.3	19.2	13.0
Stillbirth/infant death	6.4	5.9	1.8	5.9	9.2	6.1	5.1	10.3	5.9	7.3	8.7
Diagnosis related-OB	5.4	7.0	6.8	3.8	3.7	4.5	6.1	7.8	6.4	3.4	5.3
Diagnosis related-GYN	11.6	10.8	12.0	13.4	14.3	10.2	15.2	7.8	10.3	10.0	13.6
Maternal injury	6.3	4.9	6.8	6.3	8.8	4.9	5.1	4.3	8.9	6.9	8.2
Maternal death	3.1	3.2	3.1	1.7	4.6	2.4	2.9	3.4	3.0	3.4	3.9
Patient injury-GYN	28.9	29.2	21.5	35.1	23.0	29.7	27.1	26.7	33.5	35.6	25.1
Patient death-GYN	2.2	1.1	2.5	2.1	0.9	2.4	2.5	2.2	2.5	1.9	4.8
Failure of sterilization	7.0	5.9	6.5	7.1	7.8	7.7	7.6	8.6	7.4	5.0	5.8
Other	8.6	10.3	8.0	6.7	11.1	11.0	8.7	7.3	8.9	7.3	10.1
Pregnancy termination	.2	0.0	0.9	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.4

TABLE 20: LENGTH OF TIME BETWEEN INCIDENT AND FILING OF CLAIM

Subsample: Respondents who have experienced liability claims

		REGION									
	TOTAL	New Eng.	New York	Mid Atl.	So. East	Grt Lks.	Mid No.	Mid So.	West	Ca.	Fla.
Less than 6 months	10.4	7.7	5.6	8.8	8.7	10.4	10.0	8.2	18.7	14.1	16.5
More than 6 months but less than 1 year	19.1	19.8	15.7	16.5	17.5	24.5	18.2	19.7	13.1	27.3	12.4
More than 1 year but less than 3 years	33.1	31.9	22.2	49.5	32.5	31.1	30.9	32.8	31.8	28.3	44.3
More than 3 but less than 5 years	4.7	2.2	5.6	4.4	7.1	0.9	5.5	3.3	10.3	5.1	3.1
More than 5 years	4.5	2.2	7.5	5.5	4.8	3.8	3.6	2.4	3.8	8.1	0.0
Don't know	28.3	36.3	43.5	15.4	29.4	29.2	31.8	33.6	22.4	17.2	23.7

TABLE 21: EXPERIENCE WITH COMPLETED PROFESSIONAL LIABILITY CLAIMS

Subsample: Respondents who have experienced liabilitv claims

		REGION									
	TOTAL	New Eng.	New York	Mid Atl.	So. East	Grt Lks.	Mid No.	Mid So.	West	Ca.	Fla.
Yes	71.1	63.7	57.7	82.0	67.8	68.3	69.4	66.1	78.4	83.3	76.6
No	28.9	36.3	42.3	18.0	32.2	31.7	30.6	33.9	21.6	16.7	23.4

ACOG3

TABLE 22: STATUS OF INSURANCE CLAIM

Subsample: Respondents with completed liability claims

		REGION									
	TOTAL	New Eng.	New York	Mid Atl.	So. East	Grt Lks.	Mid Wo.	Mid So.	West	Ca.	Fla.
Settled	64.3	72.4	69.0	70.0	51.7	61.6	63.6	58.8	69.0	70.4	55.9
Contested	28.6	25.9	22.4	20.0	37.9	30.1	32.5	33.7	26.4	23.5	38.2
Settled without payment	7.1	1.7	8.6	10.0	10.3	8.2	3.9	7.5	4.6	6.2	5.9

TABLE 23: LENGTH OF TIME BETWEEN FILING AND SETTLING OF CLAIM

Subsample: Respondents whose claims were settled

		REGION									
	TOTAL	New Eng.	New York	Mid Atl.	So. East	Grt Lks.	Mid Wo.	Mid So.	West	Ca.	Fla.
Less 6 months	12.7	10.5	2.6	12.5	17.1	15.9	16.7	10.9	20.6	7.1	18.9
More than 6 months but less than a year	18.0	10.5	7.7	18.9	9.8	20.5	16.7	28.3	22.4	19.3	16.2
More than 1 year but less than 2 years	23.0	21.1	15.4	16.7	29.3	25.0	18.8	21.7	25.9	26.3	40.5
More than 2 years, less than 5 years	37.1	44.7	46.2	45.8	41.5	36.4	35.4	30.4	24.1	38.6	18.9
More than 5 years	9.2	13.2	28.2	6.3	2.4	2.3	12.5	8.7	6.9	8.8	5.4

LE 24: AMOUNT PAID ON PHYSICIAN'S BEHALF TO SETTLE CLAIM

sample: Respondents who settled claim

		Region									
	TOTAL	New Eng.	New York	Mid Atl.	So. East	Grt Lks.	Mid No.	Mid So.	West	Ca.	Fla.
thing paid	11.1	2.5	12.8	14.6	18.4	13.3	6.3	13.3	6.9	9.1	9.8
ss than $5,000	12.9	7.5	5.1	6.2	12.2	20.0	8.3	15.6	22.4	14.5	17.1
,000-$19,999	23.0	30.0	20.5	25.0	18.4	13.3	25.0	26.7	29.3	23.6	14.6
0,000-$99,999	28.3	22.5	33.3	31.3	24.5	35.6	27.1	22.2	19.0	34.5	29.3
00,000-$999,999	20.0	37.5	23.1	18.8	20.4	13.3	22.9	17.9	17.2	14.5	29.3
,000,000 or more	4.6	0.0	5.1	4.2	6.1	4.4	10.4	4.4	5.2	3.6	0.0
an	178,567	186,019	134,855	131,968	176,400	132,964	299,455	131,435	160,903	262,677	116,878
dian	30,000	40,000	50,000	30,000	35,000	27,000	45,000	20,000	15,000	30,000	54,000

TABLE 25: LENGTH OF TIME BETWEEN FILING OF CLAIM AND OUTCOME OF CONTESTED CASE

Subsample: Respondents whose claims were contested

		REGION									
	TOTAL	New Eng.	New York	Mid Atl.	So. East	Grt Lks.	Mid No.	Mid So.	West	Ca.	Fla.
Less than 6 months	4.7	0.0	0.0	0.0	6.0	0.0	4.8	7.6	13.0	0.0	15.3
More than 6 months, less than 1 year	14.6	33.3	15.4	0.0	27.3	13.6	4.8	19.2	13.0	5.3	11.5
More than 1 year, less than 2 years	25.6	26.7	0.0	42.9	24.2	27.3	28.6	26.9	39.1	10.5	26.9
More than 2 years, less than 5 years	44.4	40.0	61.5	42.9	27.3	45.5	38.1	46.2	34.8	68.4	46.2
More than 5 years	10.7	0.0	23.1	14.3	15.2	13.6	23.8	0.0	0.0	15.8	0.0

TABLE 26: OUTCOME OF CONTESTED CASE

Subsample: Respondents who have contested a case

		REGION									
	TOTAL	New Eng.	New York	Mid Atl.	So. East	Grt Lks.	Mid No.	Mid So.	West	Ca.	Fla.
Won	80.9	73.3	61.5	71.4	87.9	86.4	80.0	85.2	82.6	84.2	76.9
Lost	15.1	20.0	23.1	21.4	12.1	13.6	12.0	14.8	13.0	15.8	11.5
Case was dropped	4.0	6.7	15.4	7.1	0.0	0.0	8.0	0.0	4.3	0.0	11.5

ACOG?

TABLE 27: PERCENT RESPONDING THAT INCREASE IN MALPRACTICE SUITS INCREASED SPECIFIC ACTIVITIES IN PRACTICE

		Region									
	TOTAL	New Eng.	New York	Mid Atl.	So. East	Grt Lks.	Mid No.	Mid So.	West	Ca.	Fla.
Provide written or taped information to patients	49.1	39.7	43.1	54.9	46.3	43.7	47.9	50.0	50.6	59.0	43.3
Obtain written informed consent	43.1	46.6	42.1	41.1	37.5	36.1	31.1	46.8	42.0	61.5	37.1
Explain potential risks of recommended procedures	64.4	65.5	67.2	68.5	54.3	50.0	66.2	73.4	59.3	74.4	54.3
Document other activities	68.2	69.0	72.4	68.5	66.7	62.5	66.2	72.2	66.7	67.9	71.4
Referrals to other physicians	37.0	36.8	50.0	38.0	37.8	34.3	25.7	35.9	39.5	37.2	35.2
Consultation with other physicians	44.2	44.8	48.3	47.9	37.0	42.3	37.8	44.9	48.8	46.2	42.0
Testing and diagnostic procedures	67.8	58.6	77.6	71.2	62.2	67.6	70.3	64.1	61.7	73.1	68.1
Monitoring procedures	58.8	50.0	67.2	60.6	56.3	52.1	56.2	59.2	61.3	62.3	60.6
Staff presence at examinations	13.6	10.5	21.1	12.7	13.8	10.1	4.1	14.3	14.8	15.4	22.7
Other	31.9	16.7	40.0	28.6	50.0	26.7	11.1	30.8	33.3	40.0	30.0

ACOG

TABLE 28: CHANGES IN PERSONAL PRACTICE AS A RESULT OF THE RISK OF MALPRACTICE

		REGION									
	TOTAL	New Eng.	New York	Mid Atl.	So. East	Grt Lks.	Mid No.	Mid So.	West	Ca.	Fla.
Decreased number of deliveries	13.7	6.8	16.5	10.4	13.7	21.7	11.0	11.0	10.7	15.5	19.7
Decreased high-risk obstetrical care	23.1	10.7	29.9	21.9	15.4	31.9	25.0	16.3	16.1	33.8	30.7
No longer practice obstetrics	12.3	15.5	8.7	14.6	13.2	13.2	7.4	12.2	9.4	11.3	24.4
Decreased gynecological surgery	6.9	2.9	11.0	7.3	9.3	10.9	7.4	2.3	4.0	6.3	7.9
No longer do gynecological surgery	3.3	2.9	3.1	6.2	4.4	6.2	1.5	2.3	2.7	0.7	3.1
No changes in personal practice	62.9	71.8	55.9	59.4	65.9	53.5	70.6	70.9	71.1	57.7	44.1
Made any changes in obstetrical practice	35.0	25.3	39.9	37.1	30.6	44.9	27.7	27.9	27.6	42.4	53.3

TABLE 29: PROFESSIONAL FEES AFFECTED BY INCREASE IN COST OF PROFESSIONAL LIABILITY INSURANCE

		REGION									
	TOTAL	New Eng.	New York	Mid Atl.	So. East	Grt Lks.	Mid No.	Mid So.	West	Ca.	Fla.
Yes	82.9	76.9	93.8	84.6	84.9	73.0	89.0	71.7	88.7	84.1	94.7
No	17.1	23.1	6.2	15.4	15.1	27.0	11.0	28.3	11.3	15.9	5.3

ACOG

TABLE 30: ESTIMATE OF INCREASE IN PROFESSIONAL FEES RESULTING FROM INCREASES IN MALPRACTICE PREMIUMS SINCE 1983

Subsample: Respondents whose annual premiums have increased

		REGION									
	TOTAL	New Eng.	New York	Mid Atl.	So. East	Grt Lks.	Mid No.	Mid So.	West	Ca.	Fla.
0-5%	11.1	9.0	1.7	11.4	6.4	23.4	9.8	16.9	12.5	12.7	4.2
6-10%	28.3	32.1	12.8	25.0	25.6	34.0	31.7	36.3	31.2	33.1	16.0
11-15%	21.7	17.9	12.8	27.3	28.2	17.0	22.0	21.8	24.2	21.2	21.0
16-20%	13.4	19.2	16.2	14.8	10.9	9.6	10.6	12.1	13.3	12.7	21.0
21-25%	11.2	9.0	18.8	11.4	13.5	6.4	13.0	7.3	8.6	9.3	16.8
26-30%	6.2	5.1	11.1	4.5	8.3	4.3	6.5	3.2	5.5	4.2	10.9
31-35%	2.8	3.8	6.8	2.3	1.9	2.1	4.1	0.8	3.1	1.7	2.5
36-40%	3.3	3.8	14.5	1.1	1.9	1.1	1.6	0.8	1.6	3.4	4.2
Over 40%	2.0	0.0	5.1	2.3	3.2	2.1	0.8	0.8	0.0	1.7	3.4

THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

Dear Colleague:

Professional liability and its costs have been key concerns for the practice of obstetrics and gynecology for the past decade. Professional liability insurance has again assumed crisis proportions, both in affordability and availability.

As this issue is addressed by medicine and legislators at the state and national level, we have greater need for accurate data. We recognize that you recently received a College survey on practice management, and apologize for submitting another so soon. By using the same sample of our Fellowship, our information on professional liability is enhanced by the demographic data obtained in the earlier survey. Please complete and return this survey **even if you did not complete** the survey on practice management. The validity and credibility of our data is greatly affected by the response rate we achieve.

To better serve you, we again need your time and cooperation to complete this questionnaire. We urge your early response.

Sincerely,

Keith C White

Keith C. White, M.D., FACOG
Director
District and Section Activities

THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS SURVEY OF PROFESSIONAL LIABILITY

INTRODUCTION

Thank you for participating in the Professional Liability survey. Your responses to the survey will be **completely confidential.** No one from the College will have access to the returned questionnaires. Questionnaires are being sent directly to Needham Porter Novelli for analysis, and findings will be reported in grouped form only.

Please read the questionnaire carefully. Most questions call for only **one** answer unless specified otherwise. For each question circle the most appropriate answer or fill in the blank. Some questions have two parts depending upon your answer. If you select the "other" response for a question, please specify the nature of your answer.

Given the scientific nature of the sample, it is very important that you complete the questionnaire and return it in the enclosed stamped envelope **within 10 days.**

Thank you for your time and effort in this very important matter.

Section I

First, we would like you to answer some questions concerning you and your type of practice. This information will be important in analyzing responses to later items.

1. Are you currently practicing medicine?
   1. Yes
   2. No
      (If no, **do not continue. Please return blank questionnaire** in the envelope provided. Thank you.)

   1a. If you are currently in private practice, is your predominant type of practice: (Circle only **one**)
      1. Fee for service, **solo practice**
      2. Fee for service, **single specialty** partnership or group practice (How many physicians are in your partnership or group? ______)
      3. Fee for service, **multispecialty** partnership or group (What specialties other than OB/GYN are in your practice?
         ____
         ____
         ________________________________)
      4. Salaried employee of fee for service practice
      5. Salaried employee of Health Maintenance Organization, hospital, etc.
      6. Other (please specify: ________________________)

2. Age: ______ years

3. Sex: 1. Male
   2. Female

4. How many years have you been in practice (not including residency)? ______ years

5. Please specify the state in which your practice is located:
   ____

6. Approximately what was your total **gross** income from medical practice in 1984? $ ________________________

7. Approximately what percent of your practice is (Percents should add to 100%):
   a. obstetrics _____% If 0% obstetrics, ANSWER QUESTION 7a
   b. gynecology _____%
   100%

   7a. If you currently do not practice obstetrics at all, did you: (Circle only **one**)
      1. Never practice obstetrics
      2. Stop at age ______ (specify age)

8. On average, how many deliveries do you personally perform per month? ______ (Please specify a number)

9. Of your **obstetrical practice,** what percent of your patients would be considered high risk: ______%

10. Of your **gynecology-related practice,** what percent is spent on well-patient care: ______%

11. Which of the following full- or part-time staff positions exist in your office? (Circle **all** that apply)
    1. RN
    2. Nurse practitioner
    3. Nurse midwife
    4. LPN
    5. Lab Technician
    6. Office Manager
    7. Billing clerk
    8. Receptionist or other office personnel
    9. Other (Specify): ________________________
    ____

Section 2

The next section deals with questions regarding professional liability insurance.

12. Are you covered by professional liability (malpractice) insurance?

    1. Yes (SKIP TO QUESTION 13)
    2. No

    12a. What is the major reason you decided not to have professional liability insurance? (Circle only one)

    1. Don't need it
    2. Can't afford it
    3. Philosophically opposed to it
    4. Not available at any price
    5. Available, but limits offered are too low to retain my hospital privileges
    6. Other (Specify): ______________________________

    12b. How long have you been without professional liability insurance?

    1. Less than 6 months
    2. Between 6 months and a year
    3. 1–5 years
    4. More than 5 years

13. Have you ever changed liability insurance companies?

    1. Yes
    2. No (SKIP TO QUESTION 14)

    13a. How many times have you changed? _______ (Specify a number)

    13b. What were the major reasons for the change? (Circle all that apply)

    1. State or area regulations
    2. Old company no longer offers insurance
    3. Old company dropped my coverage
    4. New company is less expensive
    5. The limits offered by the old company were too low to retain my hospital privileges
    6. Switched type of insurance (claim-made; occurrence)
    7. Other (Specify): ______________________________

14. Do you have a choice regarding the amount of liability insurance coverage you can get? (Circle only one)

    1. Yes
    2. No, because of state regulations
    3. No, because of hospital regulations
    4. No, because I am not involved in the decision
    5. No, because of economic considerations
    6. No, because of insurance company regulations
    7. No, other (Specify): ______________________________

15. Do you have a choice regarding the carrier of your primary coverage?

    1. Yes
    2. No
    3. Don't know

16. What kind of professional liability insurance policy do you have?

    1. Occurrence
    2. Claims-made
    3. Don't know

17. What are the limits of your primary coverage? (Specify amount to nearest dollar)

    $______________ per claim

    $______________ aggregate

    ________ don't know (please check)

18. Approximately what was the annual cost of your primary coverage in 1984? (Specify amount to nearest dollar) $ ______________

19. Do you carry excess/umbrella/patient compensation fund coverage?

    1. Yes
    2. No (SKIP TO QUESTION 20)
    3. Don't know (SKIP TO QUESTION 20)

    19a. How much excess coverage? $______________ (Specify amount to nearest dollar)

    19b. What is the annual cost? $______________ (Specify amount to nearest dollar)

    19c. Is the excess coverage required by state or hospital regulation? (Circle all that apply)

    1. Yes, by the state
    2. Yes, by the hospital
    3. No
    4. Don't know

20. Approximately what percentage of your gross income from medical practice does your total professional liability premium represent? _______ %

21. Other than premium costs, have you incurred any other financial costs, such as additional annual assessments, as a direct result of possessing professional liability insurance?

    1. Yes
    2. No (SKIP TO QUESTION 22)
    3. Don't know (SKIP TO QUESTION 22)

    21a. What are these other financial costs? ______________________________

22. Since 1983 has your annual premium increased?

    1. Yes
    2. No (SKIP TO QUESTION 23)

    22a. How much has it increased since 1983? (Specify amount to nearest dollar) $ ______________

    22b. When was the most recent increase? _______ month(s) ago (Specify a number)

Section 3

The final section of the questionnaire focuses on experience with professional liability claims.

23. Have you ever had a professional liability (medical malpractice) claim filed against you?

1. Yes
2. No (SKIP TO QUESTION 51)

24. How many claims have been made against you?
(Specify number of claims) ______

25. Below is a list of allegations that could form the basis or bases for a malpractice claim. For eachyclaim filed against you, please enter the 2-digit code that identifies the specific allegation that formed the primary and secondary basis for each claim. (Enter 2-digit code numbers from the list in the appropriate spaces below for as many claims as you have experienced.)

2-Digit Code	
01	Brain damage/injury to infant
02	Stillbirth/infant death
03	Diagnoses-related—Obstetrical
04	Diagnoses-related—Gynecological
05	Maternal injury
06	Maternal death
07	Patient injury—Gynecological
08	Patient death—Gynecological
09	Failure of sterilization
10	Other (please specify where entered)

25a. Claim #1 primary: ______
secondary: ______

25b. Claim #2 primary: ______
secondary: ______

25c. Claim #3 primary: ______
secondary: ______

25d. Claim #4 primary: ______
secondary: ______

25e. Claim #5 primary: ______
secondary: ______

25f. Claim #6 primary: ______
secondary: ______

26. Have you experienced any **completed** professional liability claims?

1. Yes
2. No (SKIP TO QUESTION 50)

Please think about the **completed** professional liability claim you consider most **serious or significant.** Answer questions 27 through 49 with reference to that particular claim.

27. What were the specific allegations which were the primary and secondary bases of this particular claim? (Enter the 2-digit code numbers from the list below. If "Other," please specify.)

2-Digit Code	
01	Brain damage/injury to infant
02	Stillbirth/infant death
03	Diagnoses-related—Obstetrical
04	Diagnoses-related—Gynecological
05	Maternal injury
06	Maternal death
07	Patient injury—Gynecological
08	Patient death—Gynecological
09	Failure of sterilization
10	Other (please specify where entered)

Primary allegation: ______
Secondary allegation(s): ______
______
______

28. In what year was the claim initiated, i.e., officially filed?

19______ (Specify year)

29. Aside from yourself, were there any other individuals or institutions named in the suit?

1. Yes
2. No (GO TO QUESTION 30)

29a. Who else was named? (Circle all that apply)

1. My partner(s)
2. Other physicians
3. Nurse(s)
4. Nurse midwife (wives)
5. Hospital
6. Clinic
7. Free-standing birthing center
8. Other (Specify): ______________________

30. What was your professional relationship to the patient?

1. I was the patient's attending physician
2. The patient's physician was my partner or member of my group practice
3. I served as a consultant in the case
4. I was the department chairman or on the teaching staff
5. Other (Specify): ______________________

31. In what kind of setting did the incident that served as the basis for the claim occur?

1. Office
2. Hospital
3. Patient's home
4. Clinic
5. Free-standing birthing center
6. Other (Specify): ______________________

32. How long was it between the time that the incident occurred and when the official claim was filed?

    1. Less than a month
    2. More than a month but less than 6 months
    3. More than 6 months but less than a year
    4. More than a year but less than 3 years
    5. More than 3 years but less than 5 years
    6. More than 5 years but less than 10 years
    7. More than 10 years but less than 15 years
    8. Fifteen years or more
    9. Don't know

33. Did you have professional liability insurance for the period covering the incident on which the claim was based?

    1. Yes
    2. No (SKIP TO QUESTION 37)

34. How did your insurance company react to the claim? (Circle all that apply)

    1. Suggested an immediate settlement (ANSWER QUESTION 34a)
    2. Discussed the case with me
    3. Examined my medical records
    4. Carried on an evaluative procedure
    5. Informed me that my insurance would be affected
    6. Other (Specify): ______________________

    34a. Did a settlement occur at this point?

    1. Yes
    2. No (SKIP TO QUESTION 35)

    34b. Did you consent to the settlement?

    1. Yes (SKIP TO QUESTION 39)
    2. No (SKIP TO QUESTION 39)

35. Did your insurance company bring a defense attorney in on the claim?

    1. Yes
    2. No (GO TO QUESTION 37)
    3. Don't know

    35a. When was the attorney first brought in on the claim? (Circle only one)

    1. Immediately
    2. After initial discussion and evaluation
    3. During the discovery process
    4. Other (Specify): ______________________

36. At any point, did you request a change of the defense attorney assigned by the insurance company?

    1. Yes
    2. No (SKIP TO QUESTION 37)

    36a. What action was taken on your request?

    1. A new attorney was assigned to my case
    2. The insurance company refused to assign a new attorney
    3. Other (Specify): ______________________

37. Did you personally hire your own attorney?

    1. Yes
    2. No (GO TO QUESTION 38)

    37a. Why did you personally hire an attorney? (Circle all that apply)

    1. The insurance company did not immediately bring in an attorney
    2. I did not like the insurance company's attorney
    3. I felt I needed additional protection
    4. The insurance company recommended it
    5. Other physicians I know suggested that I do so
    6. I didn't have an insurance company representing me (no professional liability insurance)
    7. Other (Specify): ______________________

38. Was the claim settled or was it contested to a final conclusion?

    1. Settled Year settled: 19______
    2. Contested (SKIP TO QUESTION 41)

39. How much was paid on your behalf to settle the claim? (Specify amount to nearest dollar) $______

40. How long was it between when the claim was filed and settlement reached?

    1. Less than a month
    2. More than a month but less than 3 months
    3. More than 3 months but less than 6 months
    4. More than 6 months but less than 1 year
    5. More than 1 year but less than 2 years
    6. More than 2 years but less than 5 years
    7. More than 5 years

    SKIP TO QUESTION 43 IF A SETTLEMENT WAS REACHED WITHOUT FURTHER CONTEST.

41. Given that the case was contested to a conclusion, what was the outcome?

    1. I won (SKIP TO QUESTION 42)
    2. I lost

    41a. How much was paid on your behalf as a result of the outcome? (Specify amount to nearest dollar) $______

42. How long was it between when the claim was filed and the outcome reached?

    1. Less than a month
    2. More than a month but less than 3 months
    3. More than 3 months but less than 6 months
    4. More than 6 months but less than 1 year
    5. More than 1 year but less than 2 years
    6. More than 2 years but less than 5 years
    7. More than 5 years

43. What was your initial opinion of the claim?

    1. There was some legitimate question regarding the medical procedure(s) used
    2. It was a bad medical outcome but not malpractice
    3. Other (Specify): ______________________

44. How do you feel about the way this claim was handled by the insurance company?

1. Very satisfied
2. Moderately satisfied
3. Neither satisfied nor dissatisfied
4. Moderately dissatisfied
5. Very dissatisfied
6. Insurance company did not handle claim

45. Based on this particular medical malpractice experience, what was your general opinion about the legal process?

1. It was generally fair
2. It was generally unfair
3. No opinion

46. Based on this particular medical malpractice experience, what was your opinion of your attorney?

1. Very satisfied
2. Moderately satisfied
3. Neither satisfied nor dissatisfied
4. Moderately dissatisfied
5. Very dissatisfied
6. No attorney was involved on my behalf

47. Did the insurance company make any changes in your insurance as a result of the claim?

1. Yes
2. No (SKIP TO QUESTION 48)

47a. What kind(s) of changes were made? (Circle all that apply)

1. Increased my premiums
2. Forced an increase in the amount of insurance I need to carry
3. Terminated my insurance
4. Other (Specify): ______________________

48. Did you change your insurance in any way?

1. Yes
2. No (SKIP TO QUESTION 49)

48a. What kind of change(s) did you make? (Circle all that apply)

1. Increased my coverage
2. Decreased my coverage
3. Changed insurance company
4. Terminated coverage altogether
5. Other (Specify): ______________________

49. Which of the following outcomes, if any, have you experienced as a result of this claim? (Circle all that apply)

1. Disruption in family life
2. Adverse effect on relations with other physicians
3. Adverse effect on hospital relations
4. Decreased enjoyment in the practice of medicine
5. Public embarrassment
6. Increased awareness of the patient's involvement in medical decisions
7. Stress (e.g., anxiety, depression)
8. Other (Specify): ______________________
9. None of the above or any others that I can think of

50. As a result of your professional liability claim experience(s), has your practice changed the frequency with which any of the following activities are performed?
(Circle one number for each activity)

	My practice has not changed	My practice has increased this activity	My practice has decreased this activity	Does not apply to my practice/ have never performed this activity
a. Provide written or taped information to patients	1	2	3	4
b. Obtain written informed consent	1	2	3	4
c. Explain potential risks of recommended procedures	1	2	3	4
d. Document other activities (office visits, phone calls, etc.)	1	2	3	4
e. Referrals to other physicians	1	2	3	4
f. Consultations with other physicians	1	2	3	4
g. Testing and other diagnostic procedures (e.g., sedimentation rates, ultra-sound)	1	2	3	4
h. Monitoring procedures	1	2	3	4
i. Staff presence at examinations	1	2	3	4
j. Other (Specify):	1	2	3	4

____

____

51. Have you made any of the following changes in your personal practice as a result of the risk of malpractice? (Circle all that apply)

1. Decreased the number of deliveries
2. Decreased the level of high risk obstetric care
3. No longer practice obstetrics
4. Decreased gynecological surgical procedures
5. No longer do major gynecological surgery
6. Have made no changes in my personal practice

52. Has the increase in the cost of malpractice insurance directly affected your professional fees?

1. Yes (ANSWER QUESTION 53)
2. No

53. What would you estimate is the increase in your professional fees resulting from increases in malpractice premiums since 1980?

1. 0–5%
2. 6–10%
3. 11–15%
4. 16–20%
5. 21–25%
6. 26–30%
7. 31–35%
8. 36–40%
9. over 40% (Please specify ______%)

Thank you very much for your assistance in filling out this survey.

Please use the enclosed stamped envelope to return this survey to the Research Department, Needham Porter Novelli, 3240 Prospect Street, N.W., Washington, D.C. 20007

PROFESSIONAL LIABILITY INSURANCE AND ITS EFFECTS: REPORT OF A SURVEY OF ACOG's MEMBERSHIP

Prepared by:
Porter, Novelli & Associates
August 31, 1983

1. INTRODUCTION

A major concern of the American College of Obstetricians and Gynecologists (ACOG), as well as healthcare administrators and professionals involved in prenatal care and delivery, is the significant and increasing cost of medical liability insurance. Liability insurance for OB/GYNs ranks among the highest for any medical speciality and is estimated to be as much as $40,000 annually in some areas of the country (e.g., New York City). ACOG is not only concerned with the impact of such insurance rates on their membership in terms of financial pressure, medical procedures and professional prestige, but also with the effect on patient medical costs and welfare.

To examine the effects of the cost of liability insurance as well as the increased risk of being sued for malpractice, a cross-sectional mail survey was conducted of a stratified random sample of ACOG's membership in the spring of 1983. The survey formed the second stage of a two stage research effort designed to obtain valid, reliable information regarding these issues. The methodology involved in this effort is described in the following section.

2. METHODOLOGY

2.1 Questionnaire Construction

The first stage of the research effort consisted of a number of in-depth interviews with local OB/GYNs, ACOG officials and other professionals with extensive knowledge of the financial structure of an OB/GYN practice (e.g., financial consultant) and knowledge of liability insurance packages (e.g., insurance broker). These preliminary interviews were designed to identify the major issues related to liability insurance and thus provide a firm foundation for developing the quantitative survey. Some of the issues addressed in the interviews included the following.

- How are fees established within the OB/GYN's practice? What expenses are considered? Who sets the fees? How often do they change?
- What are the current local medical liability insurance rates and recent increases in these rates?
- Are changes in fees related to increases in liability insurance? Is there any documentation for such a relationship?
- What information can OB/GYNs provide regarding their liability insurance rates and professional fees? What information would they be willing to provide?
- What are physicians' perceptions of the impact of increased liability insurance rates on the financial aspects of their practices?
- How best can this information regarding liability insurance and fees for OB/GYN services be obtained? How should questions be phrased? What information should be requested?

The interview results were then analyzed and a draft questionnaire was developed with the cooperation of ACOG's Department of Professional Liability.

The draft questionnaire was pretested among 10 ACOG member volunteers and the necessary minor changes were made to increase the clarity and comprehensiveness of the instrument. The final questionnaire is presented in the Appendix, as is the letter which accompanied it.

2.2 Sampling

The sampling plan was designed to ensure that nine of ACOG's districts (excluding District X) as well as the state of Florida were adequately represented so as to allow separate examination of their responses (See Chart 1). Since Districts II and IX represent the States of New York and California, respectively, the plan thus permitted the detailed analysis of three important states: New York, California and Florida. ACOG membership records for Fellows and Junior Fellows were geographically ordered by state (excluding District I and Florida) and a random sample was drawn using a sampling ratio of 1 to 5. The relatively small size of District I and Florida required that they be oversampled. The sampling ratio for District I and Florida was 1 to 3.

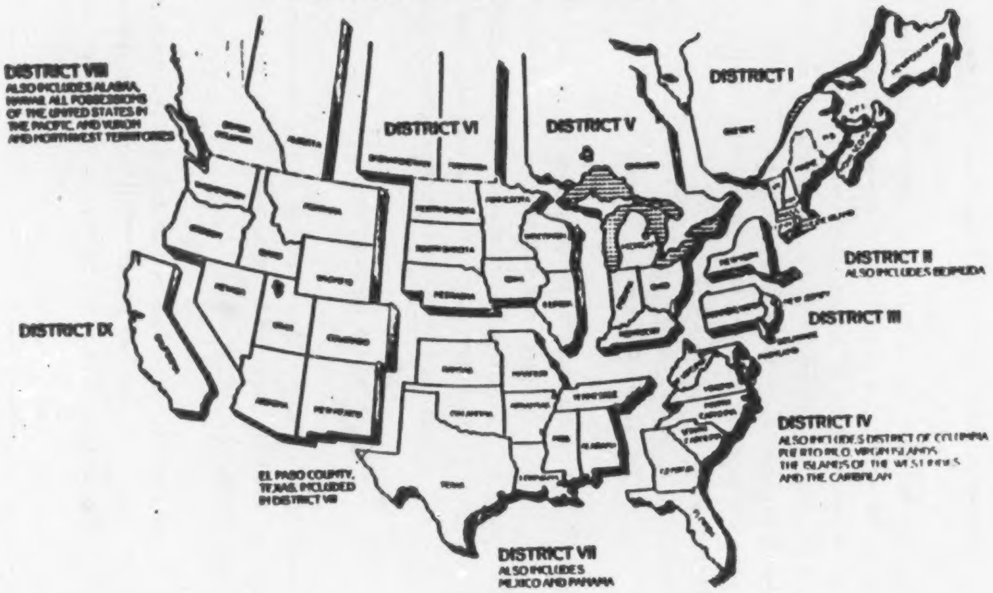
As mentioned, District X, composed of OB/GYNs in the military, was deleted from the sampling frame given that military members are not likely to be carrying their own liability insurance. In addition, two other groups were deleted from the sampling frame: members outside of the 50 states and Junior Fellows still in residency. Junior Fellows in residence were eliminated as a function of their "term date"—all those with a term date of 1987 or beyond were deleted. Retired and teaching members were deleted post hoc as a function of their self-identification in the survey responses.

CHART 1

THE NINE GEOGRAPHICAL DISTRICTS OF

The American College of Obstetricians and Gynecologists

Armed Forces District includes all Fellows on active duty in the Military Services or who, upon retirement, maintain membership in this District.


DISTRICT VIII
ALSO INCLUDES ALASKA, HAWAII, ALL POSSESSIONS OF THE UNITED STATES IN THE PACIFIC, AND YUKON AND NORTHWEST TERRITORIES
DISTRICT IX
DISTRICT VI
DISTRICT V
DISTRICT I
DISTRICT II
ALSO INCLUDES BERMUDA
DISTRICT III
DISTRICT IV
ALSO INCLUDES DISTRICT OF COLUMBIA PUERTO RICO, VIRGIN ISLANDS, THE ISLANDS OF THE WEST INDIES AND THE CARIBBEAN
DISTRICT VII
ALSO INCLUDES MEXICO AND PANAMA
EL PASO COUNTY, TEXAS, INCLUDED IN DISTRICT VIII

2.2.1 Expected Sampling Error and Statistical Significance

The reason for pursuing the sampling and field procedures outlined in the previous sections was to produce an unbiased sample of the study population which would have the same properties and characteristics of the population from which it was drawn—subject, of course, to a certain level of sampling error, and subject to deliberately imposed restrictions on the population such as the desire in this case to be overly representative of Fellows as opposed to Junior Fellows. We can derive the maximum expected sampling error for a simple random probability sample from the following formula:

$$\mathrm{Var}\ (x) = z_{\alpha/2}\sqrt{\frac{p(q)}{n-1}} \qquad \text{where:}$$

$\mathrm{Var}\ (x)$ = the expected sampling error of the mean of some variable, expressed as a proportion;

$z_{\alpha/2}$ = the standard normal score for some confidence limit:

p = some proportion of the sample displaying a certain characteristic or giving a certain answer on some variable or question;

q = $1.0 - p$; and

n = the size of the sample.

Assuming a desired confidence level of 95%, for example, the formula can be solved for the maximum expected sampling error for various sample sizes or sample splits (e.g., geographic district).

We need only to perform some simple calculations in order to test whether or not a difference between two sample proportions is statistically significant. We can obtain the sampling error of the difference between two selected samples by figuring:

$$S_d = \sqrt{S^2{}_1 + S^2{}_2} \qquad \text{where:}$$

S_1 = the total sampling error of the first sample;

S_2 = the total sampling error of the second sample; and

S_d = the sampling error of the difference.

Any difference between observed proportions that exceeds S_d represents a significant difference.

The sampling error for response distributions of groups of different sizes is given in Table 1, expressed as percentages. The unweighted bases for geographic area, the breakdown most often utilized in the analyses and included in the body of the report, are provided in Table 2. With a limited amount of interpolation and calculation, the statistical significance of differences observed in the majority of the tables following can be established fairly easily. It should also be noted that, since the estimates of pooled sampling error were calculated on a binomial distribution where $p = 0.5$, the values presented in Table 1 should be viewed as indicating the maximum difference values required for giving statistically significant contrasts; this then provides the most conservative estimates of significance.

Table 1

PERCENTAGES WHICH INDICATE A STATISTICALLY SIGNIFICANT DIFFERENCE BETWEEN TWO SAMPLES

(Assuming p=q, at 95% Confidence Level)

Size of Sample 2	Size of Sample 1				
	100	150	200	250	300
100	13.9	12.7	12.1	11.6	11.4
150		11.4	10.6	10.2	9.8
200			9.8	9.3	9.0
250				8.8	8.4
300					8.0

Table 2

OVERALL NUMBER OF ELIGIBLE* RESPONDENTS AND RESPONSE RATES, BY GEOGRAPHIC DISTRICT

(unweighted)

		N	Response Rates
TOTAL		1,915	50.10
I.	New England	170	47.75
II.	New York	177	49.72
III.	Mid Atlantic	162	46.82
IV.	Southeast Excluding Florida	218	47.70
	Florida	150	51.72
V.	Great Lakes	200	52.08
VI.	Middle North	158	47.59
VII.	Middle South	282	51.27
VIII.	West	161	55.33
IX.	California	237	51.52

* Ineligible respondents included:

- o junior fellows still in residence;
- o retired individuals;
- o teaching only individuals;
- o individuals indicating "other" as their Type of Practice; and
- o individuals who did not indicate in what state their practice is located.

3. RESULTS

3.1 Sample versus Population Characteristics

Table 3 presents the breakdown of the sample with regard to geographic districts (with Florida broken out from District IV—the Southeast—and presented separately).

As planned, the relative proportions of Fellows and Junior Fellows in the sample is not identical to that found in the population (based on late 1982 figures). In fact, the membership was sampled so that those surveyed would be most likely to be experienced with the issues surrounding professional liability insurance, establishment and maintenance of professional fees and malpractice suits in general as well as personally.

It should be kept in mind that the sample is biased toward members with more experience, and toward males as opposed to females. Remember also that this is the result of a deliberate action taken during the sampling process.

Table 3

COMPARISON OF THE MEMBERSHIP STATUS
OF THE SAMPLE VS. THE POPULATION

	% of Sample		% of Population	
	Fellows	Jr. Fellows	Fellows	Jr. Fellows
TOTAL	92.1%	7.9%	71.6%	28.4%
DISTRICT				
1	92.4	7.6	75.6	24.4
2	95.4	4.6	72.7	27.3
3	86.9	13.1	72.8	27.2
4-Florida	93.1	6.9	70.6	29.4
Florida	88.6	11.4	72.8	27.2
5	93.9	6.1	68.5	31.5
6	92.9	7.1	70.5	29.5
7	92.8	7.2	68.4	31.6
8	89.3	10.7	75.4	24.6
9	92.7	7.3	73.9	26.1

3.2 Descriptions of Practice

Tables 4 through 9 present general descriptive information about respondents' practices, as a function of geographic district. Some highlights of these data are presented below.

- In general, there are no real differences in the ages of practitioners across geographic districts. Contrary to some initial expectations, Florida ACOG members are not significantly older than members in other areas.
- California has the highest relative percentages of Solo versus Group practitioners (57.8% vs. 43.4% overall Solo; 29.5% vs. 46.2% overall Group). On the other hand, the Middle North is more highly Group practice (57%) than the overall average (46.2%), as opposed to Solo practice (28.5% vs. 43.4% overall).
- Both Florida and the Western District have relatively large numbers of OB/GYNs in practice for between 11 and 20 years, and a relatively small percent in practice for greater than 30 years.
- The type of adjunct staff member most often employed or worked with, across the board, is the Nurse Practitioner. This is especially the case for the Middle North and Mid-Atlantic; the lowest relative usage of NPs is made in the Southeast and Great Lakes regions. Physician's Assistants are relatively more popular in the Great Lakes district than in any other regions. Nurse Midwives are relatively most popular in the West, New England and the Southeast.
- With regard to obstetrical caseload, Floridians are proportionately overrepresented among the low obstetrical caseload categories (between 0 and 20%). Western OB/GYNs have the highest relative obstetrical caseload.
- Californian practitioners appear to be doing the least amount of surgery as a proportion of their total caseload.

Table 4

AGE OF RESPONDENTS, BY GEOGRAPHIC DISTRICT

(In Percents)

		GEOGRAPHIC DISTRICT									
	TOTAL	New England	New York	Mid-Atlantic	Southeast without Florida	Florida	Great Lakes	Middle North	Middle South	West	California
25-34	7.1%	5.9%	5.7%	10.6%	7.8%	6.7%	5.6%'	6.5%	9.3%	5.6%	5.6%
35-44	34.8	31.2	25.0	29.2	38.2	40.3	35.4	35.1	40.0	41.9	31.6
45-54	30.5	28.2	39.8	31.7	25.3	30.9	24.7	26.6	28.6	35.6	35.0
55-64	20.2	26.5	21.0	21.7	21.7	17.4	23.7	22.7	16.4	13.1	19.2
65 and over	7.4	8.2	8.5	6.8	6.9	4.7	10.6	9.1	5.7	3.7	8.5

Table 5

TYPE OF PRACTICE, BY GEOGRAPHIC DISTRICT

(In Percents)

		GEOGRAPHIC DISTRICT									
	TOTAL	New England	New York	Mid-Atlantic	Southeast without Florida	Florida	Great Lakes	Middle North	Middle South	West	California
Solo, fee for Service	43.4%	42.6%	46.9%	40.4%	37.6%	42.0%	43.0%	28.5%	43.3%	48.1%	57.8%
Group, fee for Service	46.2	45.6	42.3	49.7	51.8	52.7	50.5	57.0	47.9	39.4	29.5
Primarily Teaching, plus Practice	6.7	3.6	5.1	8.1	9.2	4.7	4.0	9.5	8.3	6.2	5.5
Salaried	3.7	8.3	5.7	1.9	1.4	.7	2.5	5.1	.7	6.2	7.2

Table 6

NUMBER OF YEARS IN PRACTICE, BY GEOGRAPHIC DISTRICT

(In Percents)

		GEOGRAPHIC DISTRICT									
	TOTAL	New England	New York	Mid-Atlantic	Southeast without Florida	Florida	Great Lakes	Middle North	Middle South	West	California
0 - 5 years	16.0%	10.6%	13.6%	16.0%	16.7%	16.8%	12.6%	15.9%	19.5%	17.5%	17.3%
6 - 10 years	21.8	26.5	14.7	20.4	23.3	20.1	26.1	19.7	26.6	22.5	17.3
11 - 20 years	29.2	24.7	32.7	27.2	30.2	37.6	23.2	27.4	25.5	38.8	30.4
21 - 30 years	22.4	27.7	26.0	25.9	19.5	20.2	26.2	25.5	16.6	17.5	22.8
>30 years	10.6	10.6	13.0	10.5	10.3	5.4	12.0	11.4	11.7	3.7	12.2

Table 7

PERCENT RESPONDING THAT THEY EMPLOY OR WORK WITH SPECIFIC STAFF MEMBERS, BY GEOGRAPHIC DISTRICT*

		GEOGRAPHIC DISTRICT									
	TOTAL	New England	New York	Mid-Atlantic	Southeast without Florida	Florida	Great Lakes	Middle North	Middle South	West	California
Nurse Practitioners	65.2%	67.8%	59.6%	74.2%	53.6%	65.9%	52.8%	77.2%	56.9%	72.3%	72.8%
Physician's Assistants	34.9	33.9	36.5	25.8	33.9	22.0	56.6	31.6	38.9	32.3	29.6
Nurse Midwives	24.7	33.9	25.0	22.6	33.9	26.8	13.2	15.8	19.4	36.9	23.5
Lay Midwives	.9	0	0	3.2	0	2.4	0	1.8	1.4	0	1.2

* Multiple responses acceptable.

Table 8

OBSTETRICAL CASELOAD AS A PROPORTION OF PRACTICE, BY GEOGRAPHIC DISTRICT

(In Percents)

		GEOGRAPHIC DISTRICT									
	TOTAL	New England	New York	Mid-Atlantic	Southeast without Florida	Florida	Great Lakes	Middle North	Middle South	West	California
None	13.5%	9.8%	11.6%	14.6%	14.4%	21.8%	16.9%	7.1%	14.9%	8.7%	15.2%
1-20%	11.8	11.7	19.1	12.0	13.5	12.9	9.2	12.3	10.9	5.6	10.8
21-40%	27.2	31.9	23.1	31.6	31.2	25.9	21.5	31.2	20.7	34.2	26.8
41-60%	33.7	32.5	32.9	31.6	30.7	29.3	37.9	36.4	34.8	36.0	32.5
61-100%	13.8	14.1	13.3	10.2	10.2	10.2	14.4	13.0	18.8	15.5	14.7

Table 9

SURGICAL CASELOAD AS A PROPORTION OF PRACTICE, BY GEOGRAPHIC DISTRICT

(In Percents)

		GEOGRAPHIC DISTRICT									
	TOTAL	New England	New York	Mid-Atlantic	Southeast without Florida	Florida	Great Lakes	Middle North	Middle South	West	California
None	2.0%	1.2%	3.4%	4.4%	1.9%	2.1%	2.1%	1.9%	.4%	0%	3.0%
1-10%	27.0	27.0	24.4	22.2	26.9	31.2	23.6	26.3	26.7	27.8	34.6
11-20%	25.8	24.5	25.0	18.4	29.6	27.1	25.7	19.2	25.3	33.5	29.0
21-30%	21.4	19.0	22.7	23.4	24.5	23.6	17.8	22.4	24.9	16.5	17.3
31-40%	9.0	15.3	10.2	12.0	5.6	5.6	11.0	11.5	6.2	9.5	6.9
41-50%	7.2	5.5	8.5	8.9	6.5	2.8	10.5	8.3	8.4	6.3	3.9
>50%	7.5	7.4	5.7	10.8	5.1	7.6	9.4	10.3	8.1	6.3	5.2

3.3 Professional Liability Insurance

Tables 10 through 13 present the results of several questions asking about respondents' present situation regarding type and carrier of coverage, annual cost, etc.

- There is overall a very small proportion (2.6%) of respondents who are uninsured. Because of this small percentage, meaningful analyses by district of the length of time uninsured and the rationale for being uninsured could not be performed. Overall figures indicate that most of those who are presently uninsured have been so for a year or more (92%), and more specifically for over 5 years (53%). The major reason cited is lack of money (46%) with a secondary reason of philosophical opposition (29%).

- The annual cost of primary coverage varies quite a bit between districts. A large majority (from 72.4 to 92.4%) of three areas (Southeast, Great Lakes, Middle South) pay between $2,000 and $14,999. On the other hand, three other areas (California, Florida and New York) have the largest percentages (from 79.7 to 83.6%) paying between $8,000 and $34,999).

- Both New York and Floridian respondents overwhelmingly reported an increase in their annual premiums in the past two years (81.9% and 84.6% respectively).

- New York and Florida also report the highest frequencies of increases in the past two years (New York may report greater variation than other districts because New York premiums are decided county by county).

- The most recent increases in annual costs range from 5 to 10½ months, and vary greatly in amount from district to district with New York and Florida having the largest mean total increase in the past two years. The smallest increases were in the Middle South, Great Lakes and Southeast regions.

Table 10

PERCENT OF RESPONDENTS CURRENTLY WITHOUT PROFESSIONAL LIABILITY INSURANCE: LENGTH OF TIME WITHOUT AND RATIONALE

(Unweighted Ns)

	Percent	Absolute Frequency
LENGTH OF TIME WITHOUT INSURANCE		
< 6 months	4.1%	2
6 months - 1 year	4.1	2
1 - 5 years	38.8	19
> 5 years	53.1	26
MAJOR REASON FOR NOT HAVING INSURANCE		
Can't afford it	46.2	24
Philosophically opposed to it	28.8	15
Don't need it	5.8	3
Other	19.2	10

Table 11

PRESENT ANNUAL COST OF PRIMARY COVERAGE, BY GEOGRAPHIC DISTRICT

(In Percents)

		GEOGRAPHIC DISTRICT									
	TOTAL	New England	New York	Mid-Atlantic	Southeast without Florida	Florida	Great Lakes	Middle North	Middle South	West	California
Less than $2,000	2.4%	.6%	1.8%	2.6%	2.5%	1.5%	2.7%	1.4%	2.3%	2.1%	4.5%
$2,000 - $7,999	28.4	29.1	6.0	9.7	43.1	11.0	47.9	23.0	53.0	23.2	11.4
$8,000 - $14,999	35.5	46.9	15.0	58.0	35.3	24.0	40.9	36.0	39.4	45.8	15.8
$15,000 - $24,999	23.0	21.5	39.1	26.4	15.2	50.0	5.9	26.6	3.1	23.2	44.1
$25,000 - $34,999	7.4	1.2	26.5	1.2	2.5	9.6	.5	10.8	.8	2.1	19.8
$35,000 and over	2.0	0	10.2	.6	.5	3.0	1.6	1.4	.8	.7	2.0
Don't know	1.2	.6	1.2	1.3	1.0	.7	.5	.7	.8	2.8	2.5

Table 12

PERCENT SAYING THAT ANNUAL PREMIUM INCREASED IN PAST TWO YEARS, BY GEOGRAPHIC DISTRICT

		GEOGRAPHIC DISTRICT									
	TOTAL	New England	New York	Mid-Atlantic	Southeast without Florida	Florida	Great Lakes	Middle North	Middle South	West	California
Increased	61.9%	71.5%	81.9%	69.2%	68.6%	84.6%	45.8%	62.3%	44.9%	55.8%	58.4%
Didn't Increase	28.4	16.4	11.1	21.2	23.8	11.2	46.3	21.9	47.8	31.2	28.3
Don't know	9.7	12.1	7.0	9.6	7.6	4.2	7.9	15.9	7.2	13.0	13.2

Table 13

FREQUENCY, MOST RECENT INCREASE AND AMOUNT OF INCREASE IN CURRENT ANNUAL PREMIUM, BY GEOGRAPHIC DISTRICT*

		GEOGRAPHIC DISTRICT									
	TOTAL	New England	New York	Mid-Atlantic	Southeast without Florida	Florida	Great Lakes	Middle North	Middle South	West	California
FREQUENCY OF INCREASE											
Mean	1.76	1.77	2.35	1.59	1.69	2.03	1.37	1.81	1.46	1.57	1.82
Standard Deviation	2.13	1.03	5.03	.53	.79	.77	.70	2.14	.55	.97	.99
MOST RECENT INCREASE (In months)											
Mean	7.39	6.97	10.57	5.60	7.41	6.61	7.23	8.95	9.65	5.22	5.28
Standard Deviation	6.03	3.93	7.34	4.15	5.08	2.77	5.61	9.61	6.06	2.94	6.72
TOTAL INCREASE IN PAST TWO YEARS (to nearest dollar)											
Mean	$4,607	$4,521	$8,538	$3,469	$2,804	$8,115	$2,768	$4,907	$2,669	$5,773	$4,319
Standard Deviation	4,583	2,558	5,003	2,160	2,359	5,056	4,274	3,937	3,333	8,177	3,215

* Base is those who said that current annual premium has increased in the past two years (see Table 12).

3.4 Practicing While Uninsured At Any Time

Tables 14 through 16 present the results of responses to questions concerning respondents' experiences with ever practicing while uninsured.

- Compared with the 2.6% overall who report that they are currently not covered, 10.7% have not been covered during some point in their practice. More significant however is the 25% in Florida and 25.6% in California who have done so.

- Once again, most of those who have practiced while uninsured have done so for over one year, and the most often cited reason for doing so is not being able to afford coverage. Keep in mind that the percentages presented are based on fairly small numbers, especially for respondents from New England, New York, Mid-Atlantic, Southeast and the Middle North.

- Those who have gotten insurance after being without it for a while offered a number of rationales for doing so. The most popular was that it was "too nerve-wracking to go without it." Again, keep in mind the small number of respondents answering this item.

Table 14

PERCENT INDICATING THAT THEY EVER PRACTICED WHILE NOT COVERED BY LIABILITY INSURANCE, BY GEOGRAPHIC DISTRICT

		GEOGRAPHIC DISTRICT									
	TOTAL	New England	New York	Mid-Atlantic	Southeast without Florida	Florida	Great Lakes	Middle North	Middle South	West	California
Yes	10.7%	3.5%	4.5%	5.0%	4.7%	25.0%	14.1%	5.7%	8.2%	12.6%	25.8%
No	89.3	96.5	95.5	95.0	95.3	75.0	85.9	94.3	91.8	87.4	73.5

Table 15

LENGTH OF TIME AND RATIONALE FOR BEING UNINSURED, BY GEOGRAPHIC DISTRICT*

(In Percents)

		GEOGRAPHIC DISTRICT									
	TOTAL	New England	New York	Mid-Atlantic	Southeast without Florida	Florida	Great Lakes	Middle North	Middle South	West	California
LENGTH OF TIME											
< 6 months	18.1%	20.0%	25.0%	37.5%	33.3%	16.2%	19.2%	33.3%	19.0%	10.5%	11.5%
6 mos. - 1 year	15.1	20.0	25.0	0	11.1	16.2	7.7	22.2	14.3	15.8	18.0
1 - 5 years	45.0	60.0	37.5	61.5	22.2	51.4	61.5	33.3	57.1	52.6	37.7
>5 years	21.8	0	25.0	25.0	33.3	16.2	11.5	11.1	9.5	21.1	32.8
RATIONALE											
Don't need it	7.3%	0%	0%	25.0%	20.0%	2.8%	0%	0%	9.5%	10.0%	8.2%
Couldn't afford it	44.7	66.7	25.0	50.0	20.0	47.2	36.0	44.4	42.9	30.0	57.4
Philosophically opposed to it	21.8	0	37.5	0	0	38.9	40.0	0	0	25.0	24.6
Other	26.1	33.3	37.5	25.0	60.0	11.1	24.0	55.6	47.6	35.0	9.8

* Base is those who have practiced while uninsured at some time (see Table 14).

Table 16

REASONS FOR DECISION TO OBTAIN LIABILITY INSURANCE AFTER HAVING BEEN WITHOUT IT FOR A WHILE, BY GEOGRAPHIC DISTRICT*

(In Percents)

		GEOGRAPHIC DISTRICT									
	TOTAL	New England	New York	Mid-Atlantic	Southeast without Florida	Florida	Great Lakes	Middle North	Middle South	West	California
Too nerve-wracking to go without it	44.1%	50.0%	28.6%	33.3%	45.5%	51.4%	45.0%	33.3%	38.1%	25.0%	55.1%
Couldn't get hospital privileges	31.4	50.0	71.4	11.1	63.6	40.0	30.0	22.2	23.8	12.5	28.6
Other	31.1	25.0	28.6	55.6	36.4	22.9	30.0	33.3	42.9	56.3	16.3
Acquired the necessary money	20.7	25.0	14.3	33.3	9.1	17.1	30.0	22.2	33.3	12.5	16.3
I was sued	5.6	0	14.3	0	5.7	9.1	20.0	0	0	0	4.1

* Multiple responses acceptable. Base is those who practiced at some point while not covered by liability insurance (see Table 14).

3.5 Factors in Fee Changes

A number of questions were designed to detect the procedures and factors related to the decision-making process revolving around how fees change over time. Tables 17 through 21 present these data.

- In general, between a half and two-thirds of the respondents said that they formally and systematically analyze their fees once a year, with between another 14% and 28% saying they do so twice a year.

- By far the majority of those answering said that they themselves or other members of their practice perform this analysis. Only in the Middle North is this somewhat less often the case; there, an office manager or office staff, or a financial consultant or accountant are used more than in other districts. Still, the majority in that district do it themselves.

- Respondents were asked how often their fees had increased in the past two years. Most said they'd increased either once or twice. However, some geographic differences appeared as well. A much larger proportion of the Great Lakes respondents said that they'd had no increase, compared with the total. In addition, larger proportions—again, compared with the total—of New York and Florida respondents said that they'd had three or more increases.

- Liability insurance was rated the most important of a number of specific factors in terms of its influence in decisions about fee increases. This was especially true of New York and Florida. However, following fairly closely in importance were costs of living/consumer price index and employee salaries (two factors undoubtedly closely related). The least important factors were rent and competition.

- Finally, when asked about how costs were related to decisions about fee changes, most respondents said that there was a positive correspondence between costs and fees, but that it was not generally a one-to-one correspondence. The next higher percentage said that they tried to maintain a direct relationship of costs to fees but were restricted from doing so by such factors as the UCR and competitive pricing. This latter reason was most common among Mid-Atlantic, Great Lakes and Californian respondents. Only 7% or fewer respondents said there was no correspondence between costs and fees.

Table 17

FREQUENCY WITH WHICH COSTS AND FEES ARE SUBJECT TO FORMAL, SYSTEMATIC ANALYSIS, BY GEOGRAPHIC DISTRICT

(In Percents)

		GEOGRAPHIC DISTRICT									
	TOTAL	New England	New York	Mid-Atlantic	Southeast without Florida	Florida	Great Lakes	Middle North	Middle South	West	California
Twice a year	20.4%	13.8%	18.8%	19.3%	25.8%	28.0%	14.1%	26.5%	17.4%	26.5%	17.9%
Once a year	58.1	60.5	52.8	60.2	54.8	54.0	62.6	55.5	66.2	58.1	52.3
Once every 2 - 5 years	10.1	10.2	9.1	11.8	12.0	8.0	11.8	6.5	9.3	6.5	13.2
Very rarely	6.4	7.2	9.1	5.6	4.6	5.3	8.6	7.1	4.3	3.2	8.9
Other/Don't know	5.0	8.4	10.2	3.1	2.7	4.7	3.0	4.5	2.9	5.8	7.7

Table 18

INDIVIDUAL(S) PERFORMING SYSTEMATIC ANALYSIS OF COSTS AND FEES, BY GEOGRAPHIC DISTRICT*

(In Percents)

		GEOGRAPHIC DISTRICT									
	TOTAL	New England	New York	Mid-Atlantic	Southeast without Florida	Florida	Great Lakes	Middle North	Middle South	West	California
Myself/Other members of practice	83.8%	81.8%	87.6%	89.9%	85.6%	91.2%	83.1%	72.4%	84.9%	81.2%	81.3%
Office manager or staff	23.9	17.0	14.1	18.4	25.9	22.3	21.5	33.6	24.5	28.6	28.7
Financial consultant or accountant	17.1	15.2	12.4	13.3	20.4	20.3	23.6	27.0	12.6	19.5	11.7
Other	3.9	5.5	4.7	.6	4.2	1.4	3.1	5.3	2.5	4.5	6.5

* Multiple responses acceptable.

Table 19

FREQUENCY WITH WHICH FEES HAVE INCREASED IN THE LAST TWO YEARS, BY GEOGRAPHIC DISTRICT

(in Percents)

		GEOGRAPHIC DISTRICT									
	TOTAL	New England	New York	Mid-Atlantic	Southeast without Florida	Florida	Great Lakes	Middle North	Middle South	West	California
No increase	8.4%	7.3%	9.1%	6.8%	6.0%	4.7%	20.8%	5.8%	4.3%	7.1%	10.3%
Once	39.3	34.1	30.9	44.1	41.3	29.3	41.1	35.1	45.2	31.8	45.5
Twice	41.6	47.0	39.4	37.9	43.1	44.0	34.5	49.4	43.7	50.0	33.9
Three or more times	9.1	9.1	17.7	9.9	9.2	20.6	3.0	8.4	5.7	9.1	6.4
Don't know	1.7	2.4	2.9	1.2	1.7	1.3	.5	1.3	1.1	1.9	3.9

Table 20

IMPORTANCE OF SPECIFIC FACTORS IN DECISIONS ABOUT FEE INCREASES, BY GEOGRAPHIC DISTRICT*

[redacted]

		GEOGRAPHIC DISTRICT									
	TOTAL	New England	New York	Mid-Atlantic	Southeast without Florida	Florida	Great Lakes	Middle North	Middle South	West	California
LIABILITY INSURANCE											
Mean	3.75	3.74	4.51	3.90	3.58	4.38	3.49	3.71	3.37	3.72	3.67
Standard Deviation	1.15	1.20	1.02	1.06	1.14	.92	1.14	1.30	1.18	1.12	1.26
COLA/CPI											
Mean	3.25	3.21	3.00	3.20	3.22	2.99	3.36	3.40	3.38	3.39	3.21
Standard Deviation	1.21	1.24	1.20	1.07	1.20	1.29	1.16	1.30	1.24	1.19	1.20
EMPLOYEE SALARIES											
Mean	3.16	3.05	2.78	3.07	3.30	2.94	3.15	3.06	3.34	3.41	3.20
Standard Deviation	1.13	1.13	1.18	1.04	1.16	1.10	1.09	1.13	1.21	1.02	1.03
ANALYSIS OF NET INCOME											
Mean	3.01	3.02	2.98	3.01	3.07	3.04	3.01	2.99	3.04	3.02	2.94
Standard Deviation	1.23	1.13	1.25	1.16	1.25	1.22	1.24	1.32	1.26	1.18	1.21
SUPPLIES											
Mean	2.83	2.57	2.60	2.82	2.97	2.74	2.83	2.84	2.93	3.02	2.79
Standard Deviation	1.09	1.06	1.09	1.04	1.14	1.09	.99	1.23	1.11	1.00	1.10
EQUIPMENT											
Mean	2.73	2.52	2.51	2.83	2.91	2.71	2.68	2.82	2.75	2.78	2.63
Standard Deviation	1.06	.96	1.04	.99	1.09	1.01	1.03	1.14	1.08	1.00	1.10
COMPETITION											
Mean	2.59	2.55	2.40	2.62	2.51	2.53	2.56	2.78	2.63	2.74	2.60
Standard Deviation	1.23	1.20	1.30	1.13	1.24	1.22	1.22	1.30	1.30	1.17	1.19
RENT											
Mean	2.37	2.32	2.40	2.30	2.35	2.27	2.34	2.31	2.37	2.51	2.43
Standard Deviation	1.18	1.11	1.19	1.07	1.23	1.17	1.13	1.22	1.24	1.09	1.20

* 1 = Hardly considered at all; 5 = Extremely important.

Table 21

TYPES OF RELATIONSHIPS BETWEEN COSTS AND FEES, BY GEOGRAPHIC DISTRICT

(in Percents)

		GEOGRAPHIC DISTRICT									
	TOTAL	New England	New York	Mid-Atlantic	Southeast without Florida	Florida	Great Lakes	Middle North	Middle South	West	California
Direct correspondence of costs to fees (one-to-one)	8.2%	8.2%	10.1%	10.1%	9.2%	8.2%	6.1%	8.6%	11.2%	6.5%	3.1%
Positive correspondence of costs to fees (not generally one-to-one)	63.6	61.6	67.5	54.7	67.3	68.5	58.2	61.2	67.4	68.2	61.7
Try to maintain direct relationship, but restricted by misc. factors	19.2	20.1	11.8	27.7	16.1	16.4	25.5	19.7	13.0	18.2	24.2
No correspondence	5.0	5.0	5.9	2.5	5.5	4.1	7.1	4.6	5.4	3.2	5.3
None of the above	4.0	5.0	4.7	5.0	1.8	2.7	3.1	5.9	2.0	3.9	5.7

3.6 Profile of Physicians Changing Personal Practice Due to Risk of Lawsuits

Respondents were asked to specify whether they made any of the following changes in their personal practice (multiple responses were accepted; see Table 22).

- Decreased level of high risk OB care
- Decreased number of deliveries
- Decreased gynecological surgical procedures
- No longer do major gynecological surgery
- No longer practice Obstetrics
- No change in personal practice

Floridians seemed to be more reactive to malpractice issues with regard to more general changes in their practices as well. Although about two-thirds of most of the other districts (excluding California) said that they'd made no major changes in their practice as a result of the risk of malpractice, Floridians were more likely to say that they:

- no longer practiced Obstetrics;
- had decreased the number of deliveries;
- had decreased the level of high risk obstetric care; and
- had decreased gynecological surgical procedures.

Californians were also more likely to cite a relatively decreased level of high risk obstetric care.

To better understand the increased risk of malpractice on OB/GYNs, a more detailed analysis of those OB/GYNs who stated that they were most affected by this risk was performed. All OB/GYNs, regardless of district, were classified into three mutually exclusive categories on the basis of their responses: No change in practice (68%), No longer practice obstetrics (9%) and Other changes in personal practice (23%). Responses to related survey questions were then examined for these groups.

- Physicians in the "No Obstetrics" group tended to be older than the OB/GYNs in the other two groups (62.9% were 55 or more vs. 21.5% in the "No Change" group and 30.8% in the "Other Changes" group). Given their older age, the physicians in the "No Obstetrics" group were virtually all ACOG Fellows (99.4%) and also had been in practice longer than the other OB/GYNs (68.4% over 20 years).

- The physicians in the "No Change" category were more likely to be in a group practice (51.9%) than a solo practice (36.4%) compared to the other physicians (35% group vs. 58% solo practice).

- Physicians in the "No Obstetrics" and "Other Changes" category were more likely to have been sued (72.4% and 75.3%, respectively) than those in the "No Change" group (64.2%).

- Physicians in the "No Obstetrics" category were more likely to report that their caseload included no surgical procedures (11.9%) or that more than half of their caseload was surgical procedures (16%), compared with the other categories combined (.7% no surgical procedures, 6.5% more than half of caseload surgical procedures).

- Compared to the other two categories, physicians in the "No Obstetrics" category tend to be covered by lower primary and aggregate coverage. (Specifically, 37.5% reported single claim coverage in the $100,000 - $250,000 range compared with 24.7% of the other groups combined. For aggregate coverage, 29% of the "No Obstetrics" group reported limits of between $250,001 and $500,000, compared with 16.5% of the other groups.) Possibly as a result of carrying lower limits of coverage, those in the "No Obstetrics" group reported lower annual costs for primary coverage (56.6% between $2,000 and $11,000, compared with 45.5% of the other two groups), and were less likely to say their premiums have increased over the past two years (53% vs. 62.7% for the other two groups). Physicians in the "No Obstetrics" group were also less likely to say that the fees for their professional services increased over the past two years (16.9% vs. 7.3%).

- Those in the "No Obstetrics" category were less likely to consider competition as an important factor in the decision to increase their fees (13.3% considered it very or extremely important, compared with 24.4% of the other two groups). OB/GYNs in the "Other Changes" category were more likely than the other physicians to say that the cost of their liability insurance was an important factor in deciding to increase their professional fees (75.9% cited this as very or extremely important, compared with 59.2% of "No Obstetrics" and "No Change" combined). However, both the "No Obstetrics" (78%) and "Other Changes" (85%) groups were more likely to say that the cost of malpractice insurance has directly affected their fees, compared with the "No Change" category (70.7%).

- Physicians were asked whether they had increased, decreased or not changed several specific activities within their practice as a result of the risk of malpractice suits. In almost all instances, the physicians in the "No Obstetrics" and "Other Changes" categories were much more likely to report that they had increased these activities compared to the "No Change" group. The affected activities included:

    - providing written or taped information to their patients (58.6% and 60.3% vs. 47.5%, respectively),
    - obtaining written informed consent (65.9% and 72.4% vs. 57.5%, respectively),
    - documenting activities (79% and 81.4% vs. 68.5%, respectively),
    - referrals to other physicians (55.8% and 68.2% vs. 39.1% respectively),
    - consultations (65% and 76.1% vs. 51.2%, respectively),
    - testing and diagnostic procedures (79.1% and 87.9% vs. 72.2%, respectively),
    - monitoring procedures (55.8% and 90.1% vs. 68.1%, respectively),
    - and staff presence at examinations (25.3% and 33.5% vs. 17.3%, respectively).

In addition, of the physicians who reported changes, those in the "No Obstetrics" and "Other Changes" groups were also more likely to say that the changes in their activities increased the direct medical costs to their patients (73.5% and 86.3% vs. 66.5% for "No Change") as well as to themselves (68.3% and 76.1% vs. 57.8% for "No Change").

Table 22

CHANGES IN PERSONAL PRACTICE AS A RESULT OF RISK OF LAWSUITS, BY GEOGRAPHIC DISTRICT

(In Percents)

		GEOGRAPHIC DISTRICT									
	TOTAL	New England	New York	Mid-Atlantic	Southeast without Florida	Florida	Great Lakes	Middle North	Middle South	West	California
No change	68.2%	73.9%	63.0%	72.0%	77.3%	52.7%	69.6%	69.3%	68.0%	71.8%	59.6%
Decreased level of high risk OB care	17.7	13.9	17.9	15.5	11.4	24.7	14.9	22.2	17.3	14.1	26.1
Decreased number of deliveries	10.1	8.1	17.9	5.6	6.6	19.2	9.8	7.2	11.9	10.3	9.1
No longer practice Obstetrics	9.1	6.1	8.4	9.9	6.2	17.8	11.3	6.5	11.2	7.1	10.4
Decreased gynecological surgical procedures	5.7	4.2	8.1	6.2	2.8	11.0	7.7	3.9	4.3	6.4	5.7
No longer do major gynecological surgery	2.5	1.8	4.6	3.7	1.4	2.7	4.6	.7	1.1	1.3	3.0

* Multiple responses acceptable.

3.7 Effects on Practice of Rise in Malpractice Suits

Responses to questions about changes that might have been made in the respondent's practice as a result of the rise in malpractice suits and premiums were also examined in detail as a function of geographic district and are presented in Tables 23 through 27.

- For each of eight specific activities respondents were asked to indicate whether its frequency in their practice had increased, decreased or not changed due to the rise in malpractice suits, or whether the activity was not relevant to their practice. The three activities which have apparently increased the most are:

  - testing and other diagnostic procedures;
  - documenting other activities (office visits, phone calls, etc.); and
  - monitoring procedures.

  The percentages citing increases in these activities were fairly consistent across districts. The activities resulting in the lowest percentages citing increases were staff presence at exams and referrals to other physicians. Floridian respondents seemed to be most affected by the rise in malpractice suits; they were consistently more likely than any other district group to cite increased frequency of all listed activities.

- Between two-thirds and four-fifths of respondents feel that the changes in their practice have increased direct medical costs to patients.

- Of those citing additional costs to themselves, about half said that less than 25% or none were passed on to their patients. The only real exception to this was that Floridians were least likely to say that the costs were not passed on and most likely to say that more than 75% of the costs were passed on.

- New Yorkers and Floridians were most likely to report that the increase in the cost of malpractice liability premiums directly affected their professional fees (91.3% and 90.5%, respectively, vs. 74.2% overall).

- New Yorkers and Floridians were also most likely to cite over 20% increases in their fees as a result of increases in malpractice premiums in the past two years.

Table 23

PERCENT RESPONDING THAT INCREASE IN MALPRACTICE SUITS INCREASED SPECIFIC ACTIVITIES IN PRACTICE, BY GEOGRAPHIC DISTRICT*

		GEOGRAPHIC DISTRICT									
	TOTAL	New England	New York	Mid-Atlantic	Southeast without Florida	Florida	Great Lakes	Middle North	Middle South	West	California
Testing and other diagnostic procedures	76.2%	82.3%	80.8%	77.1%	75.3%	82.1%	77.5%	68.0%	74.9%	73.9%	76.1%
Document other misc. activities	72.2	71.2	67.8	70.5	74.3	78.5	71.9	65.8	72.2	82.6	70.9
Monitoring procedures	72.3	73.9	79.5	69.2	71.2	74.3	67.2	71.5	71.5	73.4	73.8
Obtain written informed consent	61.8	58.6	53.3	62.4	62.4	65.7	59.1	53.8	64.6	70.7	64.3
Consultations with other physicians	58.0	58.5	60.5	62.2	51.2	64.8	59.6	52.0	58.2	59.6	58.3
Provide written or taped information to patients	51.2	40.8	45.2	52.9	50.5	65.7	51.9	50.7	54.2	55.0	48.4
Referrals to other physicians	47.2	44.4	49.4	52.9	43.9	54.9	48.7	36.7	45.3	46.5	51.3
Staff presence at exams	21.8	18.9	19.5	22.6	21.0	29.6	23.1	10.5	25.1	19.5	26.4

* For each of the activities listed, the percents are in relation to:
practice of activity has not changed;
practice of activity has decreased; and
does not apply to practice/have never performed activity.

Table 24

PERCENT RESPONDING THAT CHANGES IN PRACTICE HAVE INCREASED DIRECT MEDICAL COSTS TO PATIENTS, BY GEOGRAPHIC DISTRICT*

		GEOGRAPHIC DISTRICT									
	TOTAL	New England	New York	Mid-Atlantic	Southeast without Florida	Florida	Great Lakes	Middle North	Middle South	West	California
Increased costs	71.6%	75.6%	76.6%	66.9%	68.5%	80.1%	71.5%	70.3%	73.1%	73.2%	67.3%
Haven't increased costs	20.7	17.7	15.8	22.3	22.5	15.8	22.8	19.4	22.9	20.4	21.2
Practice hasn't changed	7.8	6.7	7.6	10.8	8.9	4.1	5.7	10.3	4.0	6.4	11.5

* Refers to changes in practice specified in Table 23.

Table 25

PROPORTION OF ADDITIONAL COSTS PASSED ON TO PATIENTS, BY GEOGRAPHIC DISTRICT*

(In Percents)

		GEOGRAPHIC DISTRICT									
	TOTAL	New England	New York	Mid-Atlantic	Southeast without Florida	Florida	Great Lakes	Middle North	Middle South	West	California
Costs not passed on to patients	15.9%	16.5%	14.9%	13.8%	16.5%	8.8%	16.1%	16.1%	19.0%	15.8%	17.0%
Less than 25%	35.3	40.8	37.6	40.4	35.4	32.7	38.4	27.6	33.3	34.7	34.0
26-50%	16.4	16.5	11.9	25.5	14.2	18.6	11.6	20.7	14.9	16.8	16.3
51-75%	10.2	7.8	9.9	4.3	10.2	9.7	13.4	16.1	8.6	12.6	9.9
More than 75%	22.2	18.4	25.7	16.0	23.6	30.1	20.5	19.5	24.1	20.0	22.7

* Base is those who said that costs to them had increased as a result of changes in practice which resulted from rise in malpractice suits.

Table 26

PERCENT RESPONDING THAT INCREASE IN COST OF MALPRACTICE PREMIUMS HAS DIRECTLY AFFECTED THEIR PROFESSIONAL FEES, BY GEOGRAPHIC DISTRICT

		GEOGRAPHIC DISTRICT									
	TOTAL	New England	New York	Mid-Atlantic	Southeast without Florida	Florida	Great Lakes	Middle North	Middle South	West	California
Yes	74.2%	72.2%	91.3%	81.8%	75.7%	90.5%	65.3%	76.0%	61.2%	69.3%	73.3%
No	25.8	27.8	8.7	18.2	24.3	9.5	34.7	24.0	38.8	30.7	26.7

Table 27

ESTIMATED INCREASE IN PROFESSIONAL FEES AS A RESULT OF INCREASES IN MALPRACTICE PREMIUMS IN PAST TWO YEARS, BY GEOGRAPHIC DISTRICT

(In Percents)

		GEOGRAPHIC DISTRICT									
	TOTAL	New England	New York	Mid-Atlantic	Southeast without Florida	Florida	Great Lakes	Middle North	Middle South	West	California
0-10%	51.7%	50.0%	20.1%	49.6%	65.6%	24.5%	68.9%	56.2%	67.5%	57.3%	48.1%
11-20%	29.1	30.9	31.1	33.9	26.3	38.9	21.3	27.7	24.7	30.1	31.3
21-30%	11.8	11.8	27.9	10.2	5.6	19.0	7.4	10.7	6.6	7.8	12.5
> 30%	7.4	7.2	20.7	6.3	2.6	17.6	2.4	5.4	1.2	4.9	8.1

* Base is those who responded that the increase in the cost of malpractice insurance has directly affected their professional fees (see Table 26).

3.8 Experience With Being Sued for Malpractice

A set of questions asked about the respondent's experience with being sued for malpractice. Tables 28 through 30 present these data.

- There appear to be some fairly significant geographic differences in the number of times OB/GYNs are sued. Specifically, New York has a much lower percentage of respondents who have never been sued compared with all other districts. New Yorkers are also most likely to have been sued three or more times (48.8% vs. 20% overall) confirming other reports that indicate the number of suits filed and the degree of urbanization are related. The next closest regions reporting 3+ suits are the Mid-Atlantic (31%) and California (27.3%). The Southeast region seems to have the respondents who are least likely to have been sued.

- Gynecological surgery is most likely to be the aspect of the respondent's practice which formed the basis for the malpractice claim. Deliveries constituted the second most frequently cited reason.

- Between a third and a half of respondents' most recent lawsuits were settled out of court, while about a quarter of the sample said either that the plaintiff dropped the suit or that the suit was still in progress. Florida seems to have the largest percentage of suits going to court fairly rapidly; it shows the smallest proportion of suits still in progress (14.4% vs. 23.3% overall).

Table 28

NUMBER OF TIMES RESPONDENT HAS BEEN SUED FOR MALPRACTICE, BY GEOGRAPHIC DISTRICT

(In Percents)

		GEOGRAPHIC DISTRICT									
	TOTAL	New England	New York	Mid-Atlantic	Southeast without Florida	Florida	Great Lakes	Middle North	Middle South	West	California
None	33.1%	28.4%	12.9%	30.4%	45.8%	32.2%	35.2%	23.9%	41.6%	39.9%	30.8%
Once	31.0	36.7	21.2	23.4	39.8	32.9	31.6	34.8	29.9	34.2	27.8
Twice	15.9	15.4	17.1	15.2	10.6	19.2	17.3	21.3	16.8	15.2	14.1
3 or more times	20.0	19.5	48.8	31.0	3.7	15.8	15.8	20.0	11.7	10.8	27.3

Table 29

ASPECT OF PRACTICE WHICH FORMED BASIS FOR MALPRACTICE SUIT/CLAIM*

(In Percents)

		GEOGRAPHIC DISTRICT									
	TOTAL	New England	New York	Mid-Atlantic	Southeast without Florida	Florida	Great Lakes	Middle North	Middle South	West	California
Delivery	31.2%	25.6%	40.7%	30.3%	32.8%	28.0%	26.8%	36.1%	30.9%	29.9%	26.1%
Other OB care	18.5	15.7	12.7	20.2	21.6	20.0	19.7	18.0	20.0	18.6	19.3
Gynecological surgery	41.3	45.5	41.3	40.4	41.4	40.0	42.5	41.8	41.8	34.0	42.2
Other	19.8	18.2	24.7	22.0	13.8	19.0	22.0	14.8	16.4	24.7	22.4

---

* Base is those who have been sued for malpractice (see Table 28). Multiple responses acceptable.

Table 30

RESULT OF MOST RECENTLY COMPLETED LAWSUIT, BY GEOGRAPHIC DISTRICT

(In Percents)

		GEOGRAPHIC DISTRICT									
	TOTAL	New England	New York	Mid-Atlantic	Southeast without Florida	Florida	Great Lakes	Middle North	Middle South	West	California
Plaintiff dropped the suit	23.0%	17.2%	18.5%	23.6%	28.4%	18.6%	26.2%	17.4%	25.5%	22.1%	27.4%
Out of court settlement	41.6	44.0	43.2	39.6	37.1	45.4	46.8	47.1	34.2	45.3	39.5
Lost in court	2.3	3.4	4.1	3.8	.9	2.1	.8	3.3	1.9	2.1	1.3
Won in court	9.7	9.5	6.8	11.3	9.5	19.6	6.3	5.8	12.4	10.5	10.8
Still in progress	23.3	25.9	27.4	21.7	24.1	14.4	19.8	26.4	26.1	20.0	21.0

* Base is those who have been sued for malpractice (see Table 28).

3.9 The Sued Individual

A number of analyses were performed in which the number of times the respondent was sued was used as a classifactory variable. It was expected that this might provide some enlightenment regarding how sued individuals differ from non-sued individuals. The levels of the "sued" variable were:

- never sued;
- sued once;
- sued twice; and
- sued three or more times.

Table 31 presents this breakdown as a function of sex, ACOG membership status, age, years in practice and geographic district. Males are more likely to have been sued more often than females. Fellows are more likely to have been sued more often than Junior Fellows. Neither of these results is surprising given that increasing age and number of years in practice are also associated with increasing number of times sued. Both males and ACOG Fellows are more likely to be older and have been in practice longer. In addition, the increased risk of being sued seems to happen in the first ten years of practice; the proportions having been sued don't change much after those first 10 years. With regard to age, risk increases between the ages of 25 and 44 with few differences in proportions sued occurring after age 44.

Tables 32 and 33 present the percentages reporting changes in their personal practice as a function of the number of times they had been sued. The largest differences with regard to decreasing certain types of procedures generally occurred between 1 and 2 claims/suits. However, although there is a clear trend toward increasing specific practice activities as a function of times sued, the only real differences are evident between not being sued at all and being sued three or more times.

Other data, not presented here in tabular form, indicate that of those who said that increased insurance costs have affected their fees, larger percentages assert this as a function of times sued. In addition, the proportion of increased costs passed on to their patients increases as a function of times sued.

Table 31

PROFILE OF THE SUED INDIVIDUAL*

(In Percents)

Respondent Characteristic	Number of Times Sued 0	1	2	3+
TOTAL	33.1%	31.0%	15.9%	20.0%
SEX				
Male	32.4	30.6	16.1	20.9
Female	45.3	33.1	13.4	8.1
ACOG MEMBERSHIP STATUS				
Fellow	30.9	31.1	16.7	21.3
Junior Fellow	59.6	29.1	7.1	4.2
AGE				
25 - 34	54.9	29.4	9.0	6.6
35 - 44	42.6	32.4	14.6	10.4
45 - 54	25.2	29.5	17.7	27.6
55 - 64	25.4	31.1	17.4	26.1
65+	22.2	29.5	17.4	30.9
YEARS IN PRACTICE				
0 - 5	57.4	30.5	7.8	4.4
6 - 10	38.7	32.0	17.1	12.3
11 - 15	26.9	32.0	17.5	23.6
16 - 20	23.0	33.0	17.6	26.4
21 - 25	23.9	26.9	18.8	30.4
26 - 30	23.9	29.0	18.2	28.9
> 30	24.4	33.2	15.5	26.9
GEOGRAPHIC DISTRICT				
New England	28.4	36.7	15.4	19.5
New York	12.9	21.2	17.1	48.8
Mid Atlantic	30.4	23.4	15.2	31.0
Southeast excluding Florida	45.8	39.8	10.6	3.7
Florida	32.2	32.9	19.2	15.8
Great Lakes	35.2	31.6	17.3	15.8
Middle North	23.9	34.8	21.3	20.0
Middle South	41.6	29.9	16.8	11.7
West	39.9	34.2	15.2	10.8
California	30.8	27.8	14.1	27.3

* Rows add up to 100% (allowing for rounding error).

Table 32

CHANGES IN PERSONAL PRACTICE AS A RESULT OF RISK OF LAWSUIT, BY NUMBER OF TIMES SUED

(in Percents)

	TOTAL	Number of Times Sued			
		0	1	2	3+
No changes made	68.1%	75.1%	71.8%	58.9%	58.1%
Decreased level of high risk Obstetric care	17.6	14.6	14.3	23.3	22.7
Decreased the number of deliveries	10.1	6.9	9.3	12.2	14.9
No longer practice obstetrics	9.1	7.9	7.7	12.7	10.4
Decreased gynecological surgical procedures	5.6	3.0	5.2	7.4	9.2
No longer do major gynecological surgery	2.4	1.8	2.6	2.4	3.3

Table 33

PERCENT RESPONDING THAT INCREASE IN MALPRACTICE SUITS INCREASED SPECIFIC ACTIVITIES IN PRACTICE, BY NUMBER OF TIMES SUED

		Number of Times Sued			
	TOTAL	0	1	2	3+
Testing and other diagnosite procedures	83.3%	79.7%	83.0%	83.7%	88.6%
Document other miscellaneous activities	78.7	76.6	79.8	76.7	81.8
Monitoring procedures	77.5	73.7	76.9	78.8	83.0
Obtain written informed consent	67.0	68.1	65.0	67.5	68.1
Consultations with other physicians	63.3	59.4	62.4	65.3	68.8
Provide written or taped information to patients	54.9	50.4	56.5	53.6	60.0
Referrals to other physicians	51.0	46.9	47.7	54.5	59.3
Staff presence at exams	23.2	23.1	22.1	22.8	25.6

THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

Dear Doctor:

The Department of Professional Liability of The American College of Obstetricians and Gynecologists is conducting a survey to determine the degree to which increasing costs of liability insurance are having an effect upon the specialty. You were randomly selected from the Fellowship to participate in this strictly confidential survey. Your responses will permit the first in-depth national study of the impact of the professional liability problem for obstetricians and gynecologists, and factual data is essential for a meaningful response to the liability problem for physicians.

We strongly encourage you to give this your immediate attention. Please complete the questionnaire and return it in the envelope addressed to Porter, Novelli and Associates. There the questionnaires will be analyzed and the findings reported to the College. No one from the College will have access to the returned questionnaires.

Thank you in advance for your time and attention to this very important matter. Remember, every response is important to our making useful determinations about the nature and extent of the professional liability problem in America -- as it affects you, and as it affects your patients.

Sincerely,

Elvoy Raines

Elvoy Raines
Department of Professional Liability

For Office Use Only 1 - 4

THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS
STUDY OF PROFESSIONAL LIABILITY

INTRODUCTION

The Department of Professional Liability of the American College of Obstetricians and Gynecologists (ACOG) is conducting a study of the costs and effects of liability insurance on the practice of obstetrics and gynecology. You were randomly selected from ACOG's fellowship to participate in the study. Your responses will be completely confidential. No one from the College will have access to the returned questionnaires. Questionnaires will be directly sent to Porter, Novelli and Associates for analysis and findings will only be reported in aggregate form.

Given the scientific nature of the sample, it is very important that you complete the questionnaire and return it in the enclosed stamped envelope by June 10.

Please read the questionnaire carefully. Most questions call for only one answer unless specified otherwise. For each question circle the most appropriate answer or fill in the blank. Some questions have two parts depending upon your answer. The second part of the question is designated by an arrow. If you select the "other" response for a question, please specify the nature of your answer.

Thank you for your time and effort in this very important matter.

SECTION 1

We would like you to answer some questions concerning you and your practice. This information is very important in analyzing responses to later items.

1. Present ACOG Membership status: 5

   1 Fellow

   2 Junior Fellow ⟶ Are you currently in residency? 1 yes 6
   2 no

2. Age: ____ Years 7-8

3. Sex: 1 Male 2 Female 9

4. Type of Practice: (CIRCLE ONLY ONE) 10

1 fee for service, solo practice
2 fee for service, group practice How many physicians in your group? ____ 11-12
3 teaching only
4 teaching (primary) plus practice
5 salaried (Health Maintenance Organization, hospital-based, etc.)
6 retired
7 other (specify ____)

5. When did you go into practice (excluding residency)? 19____ 13-14

6. Number of patients seen in an average week (approximate): ____ 15-17

7. Do you employ or work with any of the following: (CIRCLE ALL THAT APPLY)

1 nurse practitioners 18
2 nurse midwives 19
3 lay midwives 20
4 physician's assistants 21

8. State in which practice is located: ______________________ 22-23

9. Approximately what proportion of your caseload (practice) is obstetrics? ______% 24-26

10. Approximately what proportion of your caseload (practice) is spent on surgical procedures (other than deliveries)? 27-29

______%

11. With how many hospitals are you officially affiliated? 30

1 none
2 one
3 two
4 three or more

12. What percentage of your patients are:

a. ____% urban ____% suburban ____% rural
31-33 34-36 37-39

b. ____% high income ____% middle income ____% low income ____% poverty level
40-42 43-45 46-48 49-51

c. ____% transient
52-54

SECTION 2

This section is designed to determine your current and past experience with liability insurance.

1. What type of primary professional liability (malpractice) insurance are you presently covered by? 55

1 **Occurence**
2 **Claims-made**
9 **Don't Know**
3 **I am not covered by professional liability insurance** →

1a. What is the major reason you decided not to have professional liability insurance? (CIRCLE ONE) 56
1 **don't need it**
2 **can't afford it**
3 **philosophically opposed to it**
4 **other (specify ____________)**

1b. How long have you been without professional liability insurance? 57
1 **less than 6 months**
2 **between 6 months and a year**
3 **1 - 5 years**
4 **more than 5 years**

2. How long have you been covered by your present type of insurance? 58

1 just switched to it
2 1 year
3 2-5 years
4 6-10 years
5 11 or more years

3. If you have ever changed liability insurance policies, what was the major reason for the change? (CIRCLE ONLY ONE) 59

1 **have never changed policies**
2 **state or area regulations**
3 **old type no longer available**
4 **new type less expensive**
5 **new type was better**
6 **other (specify ______________________________)**

4. Do you have a choice regarding the type of liability insurance policy you can get? (CIRCLE ONLY ONE) 60

1 yes
2 no, because of area regulations
3 no, because of hospital regulations
4 no, because I am not involved in the decision
5 no, because of economic considerations

5. Do you have a choice regarding the carrier of your primary coverage? 61

1 yes
2 no
9 don't know

6. What is the source (carrier) of your primary coverage? (CIRCLE ONLY ONE) 62

1 private insurance company
2 state medical society company
3 independent physician-owned company
4 ACOG-sponsored insurance plan
5 self-insured university/hospital
6 other (specify ______________________________)
9 don't know

7. What are the limits of your primary coverage? (SPECIFY AMOUNT)

$_____,_____,_____ per claim 63-71

$_____,_____,_____ aggregate 72-80

____ don't know

8. What is the present annual cost of your primary coverage? 81-82

11 less than $2,000
12 $2,000 - 4,999
13 $5,000 - 7,999
14 $8,000 - 10,999
15 $11,000 - 14,999
16 $15,000 - 19,999
17 $20,000 - 24,999
18 $25,000 - 29,999
19 $30,000 - 34,999
20 $35,000 - 39,999
21 $40,000 and over
9 don't know

9. Have you acquired tail coverage? 83

1 yes → 9a. How much did you pay for tail coverage?
2 no
9 don't know

$_____,_____ (SPECIFY AMOUNT) 84-89

1 tail coverage was automatically acquired 90

10. Do you carry excess/umbrella/patient compensation fund coverage? 91

1 yes → 10a. How much excess coverage? $________ 92-98

10b. What is the annual cost? $________ 99-104

2 no

10c. Is excess coverage required by state or hospital regulation? 105

9 don't know

1 yes, by the state
2 yes, by the hospital
3 no
9 don't know

11. Other than premium costs, have you incurred any other financial costs, such as additional annual assessments, as a direct result of possessing professional liability insurance? 106

1 yes → 11a. What are they? ________________________

2 no ________________________________

9 don't know

12. Has your current annual premium increased in the past two years? 107

1 yes → 12a. How often has it increased? ______ times 108-109

2 no 12b. When was the most recent increase? ______ months ago 110-111

9 don't know 12c. How much was the total increased in the past two years? $______ 112-116

13. In deciding on the type of primary insurance you will get, as well as the carrier (source), did you make deliberate comparisons with other available types and carriers? 117

1 yes → 13a. What sources of information did you use? (CIRCLE ALL THAT APPLY)

2 no

1 other physicians 118
2 insurance brokers 119
3 financial consultant/accountant 120
4 articles in medical literature 121
5 legal counsel 122
6 other (specify ____________________) 123

14. Please rank order the following factors to represent how important they were in choosing the type of coverage and carrier you presently have. Indicate the most important factor with "1," the second most important with "2," etc. If a factor was not relevant at all, do not give it a number.

____ cost of coverage 124
____ permanence of coverage 125
____ insurance broker's availability/approachability 126
____ recommendation of colleagues 127
____ recommendation of accountant/financial advisor 128
____ recommendation of legal counsel 129
____ carrier is a physician owned company 130
____ other (specify ____________________) 131
____ it was the only kind available in my area 132

15. Have you ever practiced while you were not covered by liability insurance? 133

1 yes → 15a. How long did you remain uninsured? 134
2 no

1 less than 6 months
2 between 6 months and a year
3 1 - 5 years
4 more than 5 years

15b. What was the major reason you decided not to have insurance at that time? 135

1 didn't need it
2 couldn't afford it
3 philosophically opposed to it
4 other (specify ____________________)

15c. What was the major factor in your decision to obtain liability insurance?
(CIRCLE ALL THAT APPLY)

1 acquired the necessary money 136
2 too nerve-wracking to go without it 137
3 I was sued 138
4 couldn't get hospital privileges without insurance 139
5 other (specify ____________________) 140

7

16. Please estimate the number of OB/GYN's per 100 per year that are sued in your area and nationally. (Check one for your area and one nationally)

	Your Area	Nationally	141
1-5 per 100 per year	1	1	142
6-10 per 100 per year	2	2	
11-15 per 100 per year	3	3	
16-20 per 100 per year	4	4	
21-25 per 100 per year	5	5	
26-30 per 100 per year	6	6	
more than 30 per 100 per year	7	7	

17. Have you ever had a claim or suit brought against you for malpractice? 143

1 yes → 17a. How many times? _____ 144-145

2 no (PLEASE GO TO SECTION 3)

18. What was the result? (IF SUED MORE THAN ONCE, PLEASE ANSWER QUESTIONS 18-21 FOR MOST RECENT LAWSUIT THAT HAS BEEN COMPLETED) 146

1 plaintiff dropped the claim or suit

2 out of court settlement → 18a. How much was the settlement/judgment for? $__________ 147-154

3 lost in court → 18a.

4 won in court

5 first claim or suit is still in process

19. What effect did this judgment/settlement have on your liability insurance rates? (CIRCLE ALL THAT APPLY)

1 no effect 155

2 raised my premium 156

3 had to find another carrier 157

4 other (specify ______________________________) 158

5 first claim or suit is still in process 159

20. What was the time lapse between the occurrence of the incident and when the claim or suit was filed? 160-161

_____ years and _____ months 162-163

21. What aspect of your practice formed the basis for the claim? (CIRCLE ALL THAT APPLY AND SPECIFY INCIDENT)

1 delivery (specify ______________________________) 164

2 other obstetric care (specify ______________________________) 165

3 gynecological surgery (specify ______________________________) 166

4 other (specify ______________________________) 167

SECTION 3

We are interested in learning how professional fees for OB/GYN services are set. By professional fees we mean fees for your services. The questions do not refer to fees for tests, lab fees or other direct costs that are passed on to patients.

1. Please rank order each of the factors below to represent how important each was in the initial establishment of your professional fees. The most important factor should receive a rank of "1," the second most important factor a rank of "2," etc. Do not assign a number to a non-relevant factor.

___	word-of-mouth information about prevailing fees in the area	168
___	knowledge of UCR	169
___	analysis of actual costs	170
___	other (specify ______________________)	171
___	don't know--fees were already established when I joined the practice	172

2. How often are your costs and fees subjected to a formal, systematic analysis? 173

   1 twice a year
   2 once a year
   3 once every 2 - 3 years
   4 very rarely
   5 other (specify ______________________)
   9 don't know

3. Who generally performs the systematic analysis? (CIRCLE ALL THAT APPLY)

   1 myself/other members of our practice 174
   2 office manager or staff 175
   3 financial consultant or accountant 176
   4 other (specify ______________________) 177

4. How often have your professional fees increased in the last 2 years? 178

   1 fees have not increased
   2 once
   3 twice
   4 three times
   5 more than three times
   9 don't know

5. Are you directly involved in decisions concerning fee changes? 179

1 yes

2 no

6. The following factors have been suggested as influencing changes in professional fees over time. Please rate each one with regard to its importance for your practice in deciding whether or not to increase your fees.

		hardly considered at all	somewhat important	moderately important	very important	extremely important	
a.	rent	1	2	3	4	5	180
b.	employee salaries	1	2	3	4	5	181
c.	supplies	1	2	3	4	5	182
d.	cost of living / consumer price index	1	2	3	4	5	183
e.	professional liability insurance	1	2	3	4	5	184
f.	equipment	1	2	3	4	5	185
g.	competition	1	2	3	4	5	186
h.	analysis of net income	1	2	3	4	5	187
i.	other (specify __________)	1	2	3	4	5	188

7. Please circle the one statement that best describes how these cost factors figure into decisions about changes in your professional fees? 189

1 There's a direct correspondence of costs to fees; for example, a 10% rise in costs results in a 10% rise in fees.

2 There's a positive correspondence of costs to fees; for example, an increase in costs results in an increase in fees. However, there is not generally a one-to-one correspondence.

3 I try to maintain a direct relationship of costs to fees, but am restricted from doing so by other factors such as URC and "competitive" pricing.

4 There is a no correspondence between changes in our costs and our fees.

5 None of the above (please specify ______________________________)

SECTION 4

We would like you to answer some questions about how your practice may have been affected by the rise in malpractice suits and premiums.

1. As a result of the rise in malpractice suits, has your practice changed the frequency with which any of the following activities are performed? (CIRCLE ONE FOR EACH ACTIVITY)

	my practice has not changed due to the rise in malpractice suits	my practice has increased this activity due to the rise in malpractice suits	my practice has decreased this activity due to the rise in malpractice suits	does not apply to my practice/have never performed this activity	
a. provide written or taped information to patients	1	2	3	4	190
b. obtain written informed consent	1	2	3	4	191
c. document other activities (office visits, phone calls, etc.)	1	2	3	4	192
d. referrals to other physicians	1	2	3	4	193
e. consultations with other physicians	1	2	3	4	194
f. testing and other diagnostic procedures (e.g., sedimentation rates, ultra-sound)	1	2	3	4	195
g. monitoring procedures	1	2	3	4	196
h. staff presence at examinations	1	2	3	4	197
i. other (specify ____________ ____________)	1	2	3	4	198

2. Have any of the above changes in your practice increased the direct medical costs to your patients? 199

   1 yes
   2 no
   3 my practice has not changed due to the rise in malpractice suits

3. Have any of the above changes in your practice increased the cost to you of practicing medicine? 200

1 yes → 3a. What percentage of these additional costs have been passed on to your patients? 201

- 1 the costs are not passed on to my patients
- 2 less than 25%
- 3 26 - 50%
- 4 51 - 75%
- 5 more than 75%

2 no

3 my practice has not changed due to the rise in malpractice suits

4. What effect, if any, do you think the above changes have had on the quality of care you can provide to your patients? (CIRCLE ONLY ONE) 202

1 very negative effect

2 slightly negative effect

3 slightly positive effect

4 very positive effect

5 changes have not affected the quality of care

6 my practice has not changed due to the rise in malpractice suits

5. In the past few years have you made any of the following staffing changes as a result of the rise in malpractice suits? (CIRCLE ALL THAT APPLY)

1 hired more non-nursing staff (e.g., office assistants) 203

2 hired more nurse practitioners 204

3 hired more RNs, LPNs 205

4 added more physicians (or went to group practice) 206

5 increased training among non-medical staff 207

6 other (specify ______________________________) 208

7 have made no staffing changes as the result of changes in malpractice 209

6. Have you made any of the following changes in your personal practice as a result of the risk of malpractice? (CIRCLE ALL THAT APPLY)

1 decreased the number of deliveries 210

2 decreased the level of high risk obstetric care 211

3 no longer practice obstetrics 212

4 decreased gynecological surgical procedures 213

5 no longer do major gynecological surgery 214

6 have made no changes in my personal practice 215

7. Has the increase in the cost of malpractice insurance directly affected your professional fees? 216

1 yes —— 7a. What would you estimate is the increase in your professional fees resulting from increases in malpractice premiums in the past two years? 217-218

2 no

11 0 - 5%
12 6 - 10%
13 11 - 15%
14 16 - 20%
15 21 - 25%
16 26 - 30%
17 31 - 35%
18 36 - 40%
19 over 40% (please specify ______%) 219-221

Thank you for your cooperation. Any additional comments you would like to offer regarding the relationship between malpractice suits, liability insurance and your practice are welcome. 222-223

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Mr. ANTHONY. Our next witness is Ruth Watson Lubic.
Dr. Lubic.

STATEMENT OF RUTH WATSON LUBIC, PH.D., GENERAL DIRECTOR, MATERNITY CENTER ASSOCIATION, AND PRESIDENT, NATIONAL ASSOCIATION OF CHILDBEARING CENTERS

Ms. LUBIC. I am here representing the Maternity Center Association, a 70-year-old not-for-profit agency interested in improving maternity care, and I am a nurse midwife and a product of its school opened in 1931.

I am also here as president of the National Association of Childbearing Centers.

Mr. Schulze, you have five centers open in Pennsylvania, and two that have closed, one in Philadelphia that is looking forward to reopening, and the two closed because of the malpractice problems.

Mr. Anthony, you have one in Arkansas.

I am just going to hit some highlights from my submitted testimony, and the two—well, the three that I would like to hit on, one is the extraordinary inequity in premium projections made by the Joint Underwriters Association in New York. It represents for us operating the childbearing center, the demonstration model of freestanding centers opened in 1975, a 43,000-percent increase over our current rates. The current amount we are paying for the nurse midwife staff is less than $1,000. That is projected to go to over $430,000.

The figure for an individual midwife is $72,300, which is about 2½ times her income. So I think there is an extraordinary situation here.

JUA has recommended a 76-percent increase for obstetrician/gynecologists, and the media have been attracted to our problems. I was on the Phil Donahue Show last fall, and he asked me if someone was trying to get rid of us. I told him he is not the first person that has asked that question.

In addition to the disparity of premiums proposed for different kinds of professionals, there is also a disparity based on the same actuarial evidence. The actuaries advise the Medical Malpractice Insurance Association, the Joint Underwriters Association in New York, that premiums for nurse midwives functioning in settings like ours, should be $72,300. Those same actuaries have now advised the American College of Nurse Midwives, as they seek to establish an independent mutual company of their own, that $3,000 should be the premium for a nurse midwife.

There is a difference in the coverage; $72,300 was $1 to $3 million; and the $3,000 is for $250,000. But even if you quadrupled the $250,000, coming up to a million, you would still have premiums of about $12,000. So I don't know what is at the base of this kind of a discrepancy, but it seems to me that it is something that should be of interest to you.

I would like to also focus on implications for health care, if nurse midwives and birth centers are driven from the scene. One of the things that we do is care for the poor, with extraordinarily positive results. I brought along a few copies of articles from the media concerning doctors who don't deliver babies in which a doctor here in Washington is interviewed as to why he left his practice.

There is another lengthy article in the New York Times a few weeks ago which is entitled "A Doctor's View of Modern Medicine," and that is also about medical practice here in the District of Columbia, and it reads in part: "Private medicine is abandoning the poor. As a family doctor practicing in the inner city of Washington, I am embarrassed by my profession's increasing refusal to care for the indigent. It is now standard practice to ship indigent patients who need hospitalization to D.C. General from private hospitals. You are well aware of the poor rates of infant survival you have right here in the capital of this country."

The author is a family practitioner and says there are many complex factors that have entered into this response of private medicine. But he goes on to say, "But the cause that is probably most obvious to the lay public is invisible to the medical community. Medicine is less and less rooted in service and more and more based in money."

Then he goes on to assign this rationale of his to the malpractice crisis saying, "While we physicians have been unable or unwilling to recognize this increasing monetization of our work, society seems to have perceived it clearly and responded in kind."

There are many reasons for the drastic increase in malpractice judgments, but one of them is that patients are angry over the high fees physicians charge. Insurance companies recognize that patients generally sue physicians who are perceived as unsympathetic. Nurse midwives have been sued in numbers resulting in a 6 percent of their total population in the country.

I would like to suggest that birth centers provide an answer to this problem of serving the poor, and serving the poor at 40 percent of the cost of inhospital care. The results nationally have been very good, with much lower mortality rates than the results in the country as a whole.

We do police ourselves. We have standards and have started an accreditation program, and I hope that we will—those of us who are nurse midwives and functioning in out-of-hospital birthing centers—be looked at in terms of our own experience rather than being, as one insurer told me, tarred with the obstetrical brush.

[The prepared statement follows:]

Maternity Center Association/National Association of Childbearing Centers
Statement to the Subcommittee on Oversight
Committee on Ways and Means
United States House of Representatives
At Hearings on the Costs and Availability of Liability Insurance

March 24, 1986 1105 Longworth House Office Bldg.

OVERVIEW

Maternity Center Association is a 68 year old voluntary health agency with an impressive record of accomplishments in the field of maternal and child health including demonstrations of: the concept of prenatal care and of parents classes in 1918; the first American school of nurse-midwifery in 1931; preparation for participatory childbirth in 1947; and the Childbearing Center (CbC) in 1975. I am the MCA's General Director, a 1962 product of its school of nurse-midwifery on site at Kings County Hospital, Downstate Medical Center, New York. I hold a doctorate in applied anthropology and recently received an honorary Doctorate of Laws from the University of Pennsylvania for my work in developing the CbC which, according the Federal Trade Commission, has motivated improvement in the quality of care in all settings where mothers are served. I am also the President of the National Association of Childbearing Centers (NACC). My testimony today will relate to the national picture and particularly to our experience in New York City.

The CbC was developed as a demonstration in response to alienation of families from the impersonal, costly and pathology-oriented hospital birth services which were generally available in the late 60's and early 70's. It is a New York State licensed, freestanding facility which provides comprehensive maternity care to families anticipating a normal childbirth. It does so at less than 40% of the cost of in-hospital normal childbirth according to Empire State Blue Cross/Blue Shield. Care in the CbC is provided by teams of nurse-midwives, obstetricians, pediatricians and public health nurses. An obstetrician sees each mother twice in pregnancy. Although not present at birth, one is always available to receive families in the hospital should the mother best be cared for in that setting. Over 130 birth centers have opened in 31 states and MCA established the National Association of Childbearing Centers in order to educate, develop standards, collect data and begin a pilot accreditation program. Our own CbC has been operating safely for over 10 years, monitored carefully by the State Health Department, yet the organized medical professions have not altered their a priori position of disapproval. Obviously, we have thoughtful physician friends or we could not function.

CHILDBEARING CENTER PROFESSIONAL LIABILITY COVERAGE

For eight of the ten years of its existence, the CbC has been covered by the joint underwriters Association in New York State, the Medical Malpractice Insurance Association (MMIA). Total premiums over those eight years have ranged between seven and ten thousand dollars. MMIA, by legislative mandate, must insure any licensed physician who cannot otherwise get coverage. Comparatively few physicians (about 600) are covered by MMIA; many more New York State M.D.'s (about 15,000) are covered by the physician sponsored Medical Liability Mutual Insurance Company (MLMIC). The physicians who need MMIA tend to be those with high claims experience who have been dropped by other insurors. When, in late spring of 1985 the American College of Nurse-Midwives lost its national policy, New York State nurse-midwives went to Albany and persuaded the legislature to mandate their coverage by MMIA. MMIA then proposed annual premiums of $72,300 for nurse-midwives attending birth without a doctor on the premises. This figure is about 2½ times gross earnings and substantially more than obstetricians are charged. A supplemental rate filing of 85% for employers such as MCA was included. These rates were based on advice supplied by actuarial consultants and apparently reflect the high claims experience of obstetricians. Actuaries show a remarkable reluctance to take into consideration the fact that we serve families carefully screened for low risk status.

I would like to bring to your attention the fact that the proposed premiums represent a 43,000% increase in the premiums the CbC currently pays MMIA for its nurse-midwives, from just under $1,000 to over $430,000. If one used instead our current total annual MMIA premium of $7,622 as a denominator, the increase is reduced to 5500%, still an impossible figure.

CHILDBEARING CENTER CLAIMS EXPERIENCE

We do not understand what in our experience has caused such a remarkable change in previous rates which had been approved by the Insurance Department as being equitable. Certainly it is not our claims record. We have never had a suit brought against us as primary respondant. Nationally about 6% of nurse-midwives have ever been sued and NACC surveys have disclosed 12 suits involving birth centers with a total payment to date of $112,511 on five of the suits. Two of the claims went to trial with findings in favor of the center. The CbC has been "also named" in two suits neither of which was brought recently and neither of which resulted in a premium increase at the time. A third suit brought against hospital and pediatricians by attorneys in late June 1985 without the family's permission and in which we were "also named" was formally dropped when the family learned the CbC team had been named. In a letter to the attorneys, the woman said in part:

> "I must say that you acted on what you assumed were my best interests. I am currently pregnant (my due date is July 28) and I am under the care of the Maternity Center and Dr. R. I have chosen these people because I trust them and because we have the same philosophy about prenatal care, labor and delivery. You have no idea what it meant to me when you accused these people for having been responsible for my son's problem. You intruded in my life in such a way that it brought sadness into my family and shook up my relationship with these people. Dr. R. refused to continue providing care for me. So here I was, a month away from giving birth and without a doctor. Fortunately, the Maternity Center did not reject me. If they would have stopped providing care for me, where would I have gone? They are the only place in New York City that offers a setting to give birth in a home environment where your friends and family can be present at the moment of birth. So was your act really geared toward my best interests?"

This suit had been brought for $25,000,000 for delayed speech and partial loss of hearing in one ear. For MCA, the acceptability of the CbC service to families was given importance second only to safety and is displayed in characteristics which are, coincidentally, identical to prudent risk management, even though not instituted to avoid lawsuits. Families have complete access to their own records, are given an extensive educational program designed to inform and demystify care procedures and are considered an important part of the decision making team.

THE PROBLEM AND ITS IMPLICATION

In seeking national coverage for birth centers, we have been told we are "tarred with the obstetrical brush". In fact, efforts to inform insurors about the differences in practice and risk seem to fall on deaf ears. One insurance executive, when asked why his company insured high-risk obstetricians and high-risk hospitals and not low-risk nurse-midwives and low-risk birth centers responded "Yes, they're high risk, but they can afford the premiums."

But this problem is more than one of individual birth centers and midwifery practitioners closing their services as some have and more will be forced to do if no solution is found. Even more broadley, it affects the care of poor women and families in this country. Nurse-midwives have had extraordinary success in improving the health status of disadvantaged families. Fourteen of the 130 operating birth centers have been established to serve rural or urban poor. MCA itself has been working since 1978 to replicate in a low income area the personalized care given at the CbC. For seven years, lack of a hospital back-up forestalled our plan, but now St. Vincent's Hospital and Medical Center, along with the neighborhood primary care center NENA and the Community Service Society, has joined our effort to establish a CbC in the Lower East Side. Malpractice premiums which are based on obstetrical practice and experience would prevent the establishment of this sorely needed alternative.

IS THERE A SOLUTION?

The American College of Nurse-Midwives, following the cancellation of their policy, approached at least 17 insurors, each more than once, with no success. MCA's own experience with MMIA demonstrates that state JUA's are not the answer for affordable insurance. The ACNM has turned to the consideration of an independent mutual insurance company which could underwrite nurse-midwives and birth centers at reasonable rates. It is currently urging Congress to amend the 1981 Risk Retention Act so that ACNM itself could establish an on shore company which could write insurance in all fifty states, thus covering all members. They also urge the Congress to make federally-based reinsurance available and cite the plan drafted by the National Insurance Consumers Organization as a desirable model.

Senator Inouye sees potential relief in removing the exemption from anti-trust laws that the insurance industry presently enjoys.

In New York State, Governor Cuomo's commission to investigate the malpractice crisis reportedly will recommend a cap of $250,000 on pain and suffering among other measures. But this same measure taken in California has not solved the problem nor eliminated the ideological gridlock which exists between doctors and lawyers.

MCA has found the Insurance Department in New York State sympathetic. The department has twice rejected MMIA's proposed premium but the problem remains unsolved. At the core, I believe, is the insurance industry's unwillingness to acknowledge the social consequences of its acts and its tendency to excuse them in the name of business and profits. How else does one explain the paradox of the same consulting firm advising MMIA, an insuror, to charge nurse-midwives premiums of $72,300 for one million/three million coverage and yet on the same actuarial evidence proposing a $3,000 premium for $250,000 coverage when nurse-midwives consider their own company.

Up to this time the malpractice problem has been wrestled with at the state level without relief. The Congress must bring its resources to bear quickly, before the health of American families, particularly the disadvantaged, is even more severely affected. Prompt and far reaching measures are needed to prevent the closure of birth centers throughout the country and the demise of the nurse-midwifery profession, results which may not be unwelcome to those who oppose us.

Thank you for the opportunity to acquaint you with the experience and impressions of Maternity Center Association and the National Association of Childbearing Centers.

Chairman **Pickle**. Mr. Schulze, do you have any questions?

Mr. **Schulze**. Are some of the problems being caused by advances in medicine? Are we having children born who perhaps 30 years ago might not have been carried to full term?

Dr. **Jonas**. We think the new technology that has occurred in our field has had a positive impact. Infant mortality is dramatically down from 1951 when the American College was started.

There is no question, however, with our newer techniques of diagnosis about the fetal condition, we can deliver babies at a much earlier stage and expect a reasonable result.

The public's expectations for a perfect result in all obstetrical outcomes is part of the problem, because we can't expect that every one of those infants will be born in perfect condition. But there is no question about it, that the extremely small baby that we are delivering today did not survive 20 years ago, but does today.

What degree of handicap that child may have is another question.

Ms. **Lubic**. Mr. Schulze, birth centers were a response to families who were alienated from the kind of obstetrical care they found to be the conventional mode of practice, and impersonal, and dangerous, and were concerned about the routine application of some of these truly life-saving techniques that can be applied. But they also pointed to the rate of cesarean section.

At least a segment of the womanhood of this country became rather angry at what they thought was inappropriate care applied to them without them being included in the decisionmaking team. That is one of the reasons that in establishing the birth center, we try to make it as responsive to the desires of families as we possibly could and why we have in place such items as charts freely available to the family, educational programs, families being considered as part of the decisionmaking team, a 5-page consent form that goes home with the family before they even apply for acceptance.

We were trying to break down some of the problems that our obstetrical colleagues put in place with the best of intentions——

Mr. **Schulze**. Do you feel this has helped in the liability process? Do you get fewer claims?

Ms. **Lubic**. The insurers feel that this is an assistance. These are risk management items. In fact, I asked one of the major insurers, when we went looking for insurance, if he felt that this kind of alienation between provider and consumer played a part in the situation. He said he was sure that it did.

My plea is that we be studied. If, in fact, we do have lower claims experience—and it appears that way, although our lifetime in this country is short, the first school having been established in 1931, and our numbers being small—we are about one-tenth of the number that there are of obstetricians—it is pertinent to study what we are doing and look and see if it will help, rather than just say, well, because you are not an obstetrician, who have *x* claims, you will have so many because you are not educated, and so on.

Dr. **Jonas**. It is important we consider the fact that the nurse midwife may not be delivering the patient with extreme complications that the obstetricians are today, and that obstetricians have to do the surgery in the event of a major complication.

The rising cesarean section rate in the United States is in part produced by the professional liability crisis. Physicians are moving to act quickly because they are concerned that if something goes wrong, there will be litigation.

So I would agree that that rising rate, which I deplore—is in part produced by this crisis.

Ms. LUBIC. I think that allegation "you are tarred with the obstetrician's brush" has another side to it, and that is—in fact, we are teammates, and I hope I don't make it sound like anything different than that—but as Dr. Jonas pointed out, we do manage the pregnancy and birth for normal, healthy women, and we do function in a team, and when a family goes out of those criteria we do need to transfer to an obstetrician, so that is part that the insurers see. But they are unwilling to look at the fact that we do screen facts carefully.

Mr. SCHULZE. What steps, if any, have surgeons taken to decrease the number of incompetent practitioners? The attorneys come in and say we have got a lot more people out there who are incompetent, and that is the reason for this rash of claims.

What are the organized surgeons doing to cure this?

Dr. HANLON. Since our inception 73 years ago, we had a very vigorous program of weeding out incompetent surgeons, and those who fail to follow the pledge that they make for following our guidelines for appropriate practice in various ways.

I may say that that process is not facilitated by the current restrictions on peer review, and by the very great cost and difficulty that occurs when we do remove an individual from fellowship.

We have, for example, one case that has been going for 5 years now and has cost us over $800,000 thus far. The man has been discharged from the college, but not yet come to trial except for two preliminary legal skirmishes. That gives some support to the fact that we are diligent in seeking these poorly practicing individuals, but it is a very difficult process to bring them to justice.

Mr. SCHULZE. There was a recent case here in Washington that got a lot of national publicity. I am afraid it showed that no matter what you are doing, the general public thinks you are not doing enough to correct the situation.

Are you telling me it is mainly public relations?

Dr. HANLON. No; when one has over 48,000 surgeons in an organization, it is obvious that there is going to be—even a small fraction of those will constitute a significant number of individuals. And when one looks at the difficulty of bringing those individuals one by one to justice other than throwing them out of the college, I believe throwing them out of the college does not prevent their practicing. It removes a certain dignity and esteem that they may have by virtue of membership in the college, but it does not prevent their practicing surgery.

Mr. SCHULZE. Is there a better way to do it, then?

Dr. HANLON. I mentioned earlier that peer review is encompassed by great risks for those in the peer review system, by the fact that these are voluntary individuals serving without compensation and incurring thereby great risks, and our risks for officers' and individuals' liability in the pursuit of our duties, as with the other testimony you have heard today, the coverage has been halved, and the costs have been, I think, perhaps quadrupled in recent years.

Dr. JONAS. Our organization has instituted two pilot programs this year. One is a quality assurance program, a pilot project ongoing in a hospital in Indiana, and that program is designed to look at the different practice patterns of physicians in the hospital. That is the type of program that would identify the bad apples, if you will, and would provide a hospital an easy way to begin to get data on the quality of practice of the physician.

In addition, we have started a second program in which we are providing a consultation service to hospitals who would like a team of our physicians to come in and look at how obstetrics is practiced in that hospital.

Dr. BAGAN. First of all, to speak to what Dr. Hanlon said, I served on the credentials committee of the American College of Surgeons, and although it is peer review at the second level, there have been individuals who we have not recommended, even though they have been board certified, to be admitted, doing peer review of their practice. It is not of the highest quality. That does not give us access to go back to the primary site where these physicians practice.

Mr. SCHULZE. Does the average patient walk into a physician's office and say, "Are you a member of the American College of Surgeons?"

Dr. BAGAN. No one has ever asked me. I watch the patients, and they walk around and look at the various diplomas.

Dr. THOMPSON. I think the problem at present is the risk of suit against any disciplinary body, whether it be at the local hospital or credentials committee or maybe at the American Academy of Orthopaedic Surgeons' level, to provide some guidelines and standards that will set acceptable levels of practice, so that the credentials committee at the local hospital, which knows how an individual surgeon or physician practices, has something to back them up when they remove the privileges, Mr. Schulze.

Mr. SCHULZE. You don't feel that plays any part in the current liability crisis? Or do you?

The profession itself could assist in eliminating this problem by being a little firmer, changing your standards and regulations, or asking us to give you a law that allows you to bar someone from practice. There has to be some way we can do something about this.

Dr. BAGAN. One of the big problems with peer review is not that we do not know or are not aware of the problems that exist, but how to go about them even if one is conscientious. And the biggest problem is that of antitrust. Every time in our hospital we have attempted to reprimand somebody, the first thing they do is go out and hire a lawyer, and we are then in the midst of litigation, and everything becomes escalated to a secondary level. And it becomes very difficult to try to control that individual.

If he comes before the board of registration in medicine, we end up before our Supreme Court, and the case gets overturned, because there has not been the proper judicial mechanism followed. And the reason is the board is so strapped in terms of personnel available to it. If we were able to have national law in terms of antitrust, peer review could get on with it.

We had an instance in our medical society where we voted to—where somebody sued us, and we later had to settle that case, and we were then unable to get directors' and officers' liability insurance to serve as officers of the medical society.

Mr. SCHULZE. Keeps going around and around.

Thank you very much. My time has expired.

Chairman PICKLE. Thank you, Mr. Schulze.

Dr. Hanlon, you do take issue with the statement of the trial lawyers group who said that there is no medical malpractice crisis, and that indeed the situation is intolerable?

Dr. HANLON. Yes, sir.

Chairman PICKLE. And the other panelists have indicated that this is indeed a serious national crisis, a problem for physicians.

Do you think we should legislate the matter? Should we try to find an answer on the Federal level? Or should we try to encourage that more concrete steps be taken at the State level? Or, instead of that, should we try to just have a complete overhaul of the entire insurance industry or the civil jury system in this regard? Do you have any thoughts on how we should go about this?

Dr. HANLON. From a practical standpoint, the legislative initiative should be taken at the State level. I believe it has been demonstrated by the fact, for example, in California, after appropriate legislation was enacted, it is just recently after 10 years that the validity of one significant provision of that law has been acted on by the California State Supreme Court.

I think the tedious way in which a change, once enacted, runs through the court, I think speaks for itself. And I think it is granted that situations are different in different States.

It seems to me, however, to address your question directly, that it needs a national legislative initiative conjoined with the various State initiatives in a way, for example, that the Hatch bill addresses and the other legislative initiative which Dr. Jonas has mentioned, the Moore-Gephardt bill—has advantages that perhaps a fusion of those two approaches, and some others, might be appropriate. That question is answered in that way.

As far as whether the bad doctor situation, which is one of the claims of the trial lawyers, is a major issue—and if you eradicate bad doctors, the problem will go away—one can look at the statistics. The people who are sued, are often the leading practitioners. They may never have had any claims against them validated if they have been brought. This predominance of excellent physicians being sued speaks against the statement that bad doctors are a major contribution, although there are bad doctors.

The one mentioned in this vicinity here is a clear example, as is the notorious one in California some years ago, but they are a minuscule part of the overall problem of cause.

Chairman PICKLE. Do any of you dare to venture to us what would be a fair annual premium for medical malpractice insurance? For $1 million worth of insurance, what should it be?

Dr. JONAS. I really appreciated hearing Judge Bell talk about some sort of a national registry or data-gathering effort to give us information about insurance companies' experience. We cannot really answer that question unless we have some more data about what the claims are and what the premiums ought to be, and I thought his idea of a national data collection system would be very helpful in this regard.

Chairman **Pickle**. I think Mr. Bell made a good suggestion on that because we are finding we are having some difficulty getting facts. But if you have some recommendation for us to consider as an approach, we would like to have it, Dr. Jonas.

Ms. **Lubic**. I don't think 2½ times your gross salary is a solution, which is what we are confronted with in New York. And I also feel that the joint underwriters at the State level is not an answer.

I believe in Pennsylvania the joint underwriters have set an insurance rate at 20 percent of salaries. They are giving that a try. But I don't see the evidence for that. And I would come back to my observation about the actuarial advice which is being given insurers and other people, that based on the same evidence it can vary so tremendously widely as from $3,000 to $72,000, and it does not seem to be coming out of good, solid evidence for decisionmaking like this.

So I would agree that the data collection is very important.

Chairman **Pickle**. Is it true that many of our surgeons are actually quitting practice, going out of business, because of the high cost of malpractice insurance?

Dr. **Bagan**. Yes, Mr. Chairman.

I think that the question of medical liability premium as a percentage of income or salary is very difficult to arrive at, because it doesn't take into consideration States where you have both a very rural and a very urban pattern. And included in my written statement is a survey from New Hampshire, and there are some general surgeons with very fine reputations in small community hospitals in the north country where the economic conditions are not very good, and they have to pay $27,000, which is the same thing that I pay to do neurosurgery in the capital of the State, which is quite small but still the capital, in a more urban population.

These individuals are not able to continue practice which then necessitates the people from the north country of our State to have to be transferred many miles to larger institutions, which would not ordinarily be necessary had these surgeons been able to practice in their subspecialty. So, it is such a complex problem that it is not fair to be able to say that somebody in Manhattan practicing in a given field should pay 20 percent of his salary or a fixed premium, and the same for someone who is practicing in upper New York State in a very little community.

Chairman **Pickle**. Well, gentlemen, we thank you—and Dr. Lubic. I recognize that we do have a problem in this field.

If it is true that surgeons are actually ceasing practice, because of the high cost of insurance or the potential liability that they could experience that is a serious problem for this country. It is a problem we have to look at.

We thank you.

Mr. **Anthony**. Mr. Chairman, would you yield for one comment? I had to step outside and visit with some constituents. I really do want to thank the last panel. I thought they had some very excellent testimony and data that should help the committee. And I thought they came forward with some very sensible recommendations.

What impressed me most of all, they note some things that could be done within their own associations. They were willing to work with the various groups, make insurance both affordable and available.

Chairman PICKLE. Well, thank you, Mr. Anthony.

Now, last week we had a report given by Mr. Richard Willard, the Assistant Attorney General of the United States, Civil Division, Department of Justice. And he made a report in behalf of the administration's task force on tort reform, a working group's view, pertaining to the views, findings, and conclusion of that task force.

They made some recommendations to the administration, about certain facts and findings, that they think should perhaps be implemented.

I want to ask Beth Kuntz, the staff director of the subcommittee, to give us a report on that working group's findings. I do so because I want the committee to have a full report. We met with Mr. Willard last Thursday in a briefing session. I want other people to be mindful of some of the findings and recommendations that the working group has made to the administration.

So I am going to ask Beth if she would give us a report or a summation of that group's findings so we might have it as a matter of record.

Ms. KUNTZ. Thank you.

I will briefly summarize the administration's report to be inserted into the hearing record at the chairman's request.

In October of last year, the Attorney General established the Tort Policy Working Group, an interagency working group consisting of representatives of 10 agencies and the White House. One of the tasks the working group was asked to undertake was to examine the rapidly expanding crisis in liability insurance availability and affordability.

The primary contributing agencies included the Department of Justice, the Department of Commerce, and the Small Business Administration.

This report contains a number of observations, conclusions, and recommendations. First, tort law appears to be a major cause of the insurance availability/affordability crisis.

Second, to the extent that other factors—such as the recent large underwriting losses of the insurance industry—underlie this crisis, there is little the Federal Government can or should do to remedy these problems. It is likely that these problems will work themselves out in the short term as the insurance industry restores its desired level of profitability, and as other insurance industry developments are implemented.

The report continues that it seems highly unlikely, however, that these changes will substantially alleviate the crisis, particularly the affordability aspect of the crisis, without substantial reforms of tort law.

Third, the working group found nothing to support the suggestion that this crisis could be remedied through Federal regulation of the insurance industry. They also found that the State insurance regulators did not need to be addressed through Federal regulation.

Fourth, while a Federal insurance or indemnification program obviously could provide subsidized insurance where insurance is unavailable or unaffordable, for many reasons such a program would be highly undesirable and ultimately counterproductive.

The report concludes that, ultimately, State governments and courts must address the current excesses of tort law. Their active participation is essential to finding workable solutions to the increasingly debilitating problems of tort law.

The working group used basically the same 1985 insurance industry data that this subcommittee has been using. That is the best information data base.

They found in 1985 the insurance industry made an overall profit of $7.6 billion. That number is a result of net investment income of $32.8 billion, less $25.2 billion in underwriting losses.

They note that this profit level was below the Fortune 500 median. They do not attach any blame to the insurance industry generally nor to its prior pricing or investment practices.

The working group found that in the past decade there has been an explosion of tort liability litigation in the United States. Four specific problem areas are identified and discussed:

The movement toward no-fault liability, which increasingly results in companies and individuals being found liable even in the absence of any wrongdoing on their part; the undermining of causation through a variety of questionable practices and doctrines which shift liability to "deep pocket" defendants even though they did not cause the underlying injury or had only a limited or tangential involvement; the explosive growth in the damages awarded in tort lawsuits, particularly with regard to awards such as pain and suffering or punitive damages; and the excessive transaction costs of the tort system, in which virtually two-thirds of every dollar paid out through the system is lost to attorneys' fees and litigation expenses.

The working group recommends eight reforms of tort law that should significantly alleviate the crisis in insurance availability and affordability. The working group does not at this time recommend how these reforms should be implemented, whether at the Federal or State level, or through legislative or judicial modification of the law; nor are these reforms meant to be an exhaustive list of potential reforms.

The group's recommended reforms are: Return to a fault-based standard for liability; base causation findings on credible scientific and medical evidence and opinions; eliminate joint and several liability in cases where defendants have not acted in concert; limit noneconomic damages, such as pain and suffering, mental anguish, or punitive damages, to a fair and reasonable maximum dollar amount; provide for periodic, instead of lump sum, payments of damages for future medical care or lost income; reduce awards in cases where a plaintiff can be compensated by certain collateral sources to prevent a windfall double recovery; limit attorneys' contingency fees to reasonable amounts on a sliding scale; and encourage use of alternative dispute resolution mechanisms to resolve cases out of court.

Thank you, Mr. Chairman.

[The report follows:]

Report of the Tort Policy Working Group on the Causes, Extent and Policy Implications of the Current Crisis in Insurance Availability and Affordability

February 1986

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INTRODUCTION

AND

EXECUTIVE SUMMARY

In October of last year the Attorney General established the Tort Policy Working Group, an inter-agency working group consisting of representatives of ten agencies and the White House. One of the tasks the Working Group was asked to undertake was to examine the rapidly expanding crisis in liability insurance availability and affordability.

The following is the report of the Tort Policy Working Group on the causes, extent and policy implications of this crisis. The primary contributing agencies included the Department of Justice, the Department of Commerce and the Small Business Administration.

Chapter 1 of the report (The Crisis in Insurance Availability and Affordability) describes in detail the significant problems many businesses, professionals and municipalities are having obtaining liability insurance. The Chapter documents a dramatic change in the last two years in the availability, affordability and adequacy of liability insurance. Where insurance is available (and in some areas it simply is not), premium increases of several hundred percent over the last year or two have become commonplace. Few if any private or public entities that rely on liability insurance have escaped the problems generated by this crisis.

Part A of Chapter 2 (The Causes of the Crisis in Insurance Availability and Affordability) reviews the current financial condition of the insurance industry, and the economic factors leading to that condition. The property-casualty industry in the past two years has suffered significant underwriting losses ($21 billion in 1984; $25 billion in 1985) which have limited its ability to offer as much insurance as its customers desire, and have made it reluctant to insure high risk activities which may expose it to further substantial underwriting losses. These underwriting losses appear to be largely a result of coverage written in the late 1970's and early 1980's which may have been underpriced due to the industry's desire to obtain premium income to invest at the then prevailing high interest rates.

Nonetheless, there is little to suggest that the recent massive increases in premiums is related solely to these losses, or that the cost of liability insurance will decline significantly as the industry limits its underwriting losses and restores its desired level of overall profitability. To the contrary, indications are that developments in tort law are a major cause for the sharp premium increases. 1/

Part B of Chapter 2 reviews the contribution of tort law to the insurance availability/affordability crisis. The Working Group found that in the past decade there has been a veritable explosion of tort liability in the United States. Four specific problem areas are identified and discussed:

- The movement toward no-fault liability, which increasingly results in companies and individuals being found liable even in the absence of any wrongdoing on their part.
- The undermining of causation through a variety of questionable practices and doctrines which shift liability to "deep pocket" defendants even though they did not cause the underlying injury or had only a limited or tangential involvement.
- The explosive growth in the damages awarded in tort lawsuits, particularly with regard to non-economic awards such as pain and suffering or punitive damages. And,
- The excessive transaction costs of the tort system, in which virtually two-thirds of every dollar paid out through the system is lost to attorneys' fees and litigation expenses.

The Working Group was particularly struck by the extraordinary growth over the last decade of the number of tort lawsuits and the average award per lawsuit. A few examples amply illustrate this point:

- Between 1974 and 1985 there has been a 758% increase in the number of product liability lawsuits filed in federal district court.
- The number of medical malpractice lawsuits per 100 physicians doubled between 1979 and 1983, and tripled during that period for obstetricians/gynecologists.
- According to a jury verdict reporting service, between 1975 and 1985 the average medical malpractice jury

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1/ The Working Group also considered whether state regulation of the insurance industry may be a cause of the crisis, and found little compelling evidence that state regulation is a major cause of these problems.

verdict increased from $220,018 to $1,017,716, and the average product liability jury verdict increased from $393,580 to $1,850,452. 2/

- A survey of punitive damage awards in Cook County, Illinois indicates that the average personal injury punitive damage award (measured in constant 1984 dollars) increased from $40,000 in 1970-74 to $1,152,174 in 1980-84.

The above data demonstrates that the insurance industry was selling coverage at constant or even reduced cost over a period of years during which tort liability was undergoing a dramatic expansion. This suggests that a major factor underlying the availability/affordability crisis is the industry's attempt to bring premiums quickly back into line with rapidly growing liability risks. 3/ The high -- and in some areas unaffordable -- insurance premiums reflect the fact that tort law is now placing a massive compensation burden on the private sector.

A second important contribution of tort liability to the availability/affordability crisis is the tremendous uncertainty that has been generated by rapidly changing standards of liability and causation. The "rules of the game" have become so unpredictable that the insurance industry often cannot assess liability risks with any degree of confidence. This appears to have severely exacerbated the problem.

Chapter 3 of the report (Recent Insurance Industry Developments) summarizes a number of responses of the insurance industry, its customers and state regulators to the crisis. These developments include the use of claims-made policies, the inclusion within policy limits of all or part of defense costs, the increasing use of self-insurance and captives, and more exacting state regulation.

In Chapter 4 of the report (Tort Law Reform) the Working Group concludes that while some of the above recent developments in the insurance industry, along with a likely improvement in the industry's financial condition, should relieve some of the current availability/affordability problems, it is unlikely that these changes will provide long-term, systemic relief without

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2/ For purposes of comparison, the dollar lost approximately half of its purchasing power during this period.

3/ While some have suggested that the dramatic premium increases are an attempt by the industry to recoup its past underwriting losses, for the reasons discussed in the report such a theory makes little economic sense.

some fundamental reforms of tort law. Indeed, there are good reasons to believe that absent such reforms, particularly the insurance affordability problem will remain a long-term fixture of the American economy.

The Working Group recommends eight reforms of tort law that should significantly alleviate the crisis in insurance availability and affordability. The Working Group does not at this time recommend how these reforms should be implemented (whether at the federal or state level, or through legislative or judicial modification of the law); nor are these reforms meant to be an exhaustive list of potential reforms. The recommended reforms are:

- Return to a fault-based standard for liability.
- Base causation findings on credible scientific and medical evidence and opinions.
- Eliminate joint and several liability in cases where defendants have not acted in concert.
- Limit non-economic damages (such as pain and suffering, mental anguish, or punitive damages) to a fair and reasonable maximum dollar amount.
- Provide for periodic (instead of lump-sum) payments of damages for future medical care or lost income.
- Reduce awards in cases where a plaintiff can be compensated by certain collateral sources to prevent a windfall double recovery.
- Limit attorneys' contingency fees to reasonable amounts on a "sliding scale."
- Encourage use of alternative dispute resolution mechanisms to resolve cases out of court.

Chapter 5 of the report (Government Insurance: A Non-Solution) details the reasons why government insurance or indemnification would be highly undesirable and would do nothing to remedy the problems underlying the availability/affordability crisis. Such a federal insurance or indemnification program would not only be extremely expensive, but also could exacerbate the problems of tort law by making the "deep pocket" of the taxpayer available in many cases. In addition, such a program could undermine public health and safety, require more extensive government regulation of private sector activities, involve the government in substantial litigation, lead to increased federal involvement in state insurance regulation, and inhibit the ability of the private sector to adapt insurance services to changing economic and social conditions.

The Conclusion to the report lists five conclusions as to the appropriate response of the federal government to the current crisis in insurance availability and affordability. In sum, the Working Group concludes that while there are a number of factors underlying the insurance availability/affordability crisis, tort law is a major cause which the federal government can address in various sensible and appropriate ways. As for some of the other factors underlying the crisis, such as the insurance industry's recent large underwriting losses, there is little the federal government can or should do to remedy these problems.

In that both the tort liability and insurance developments in this report are highly dynamic, and because more detailed data and other studies undoubtedly will become available, the Working Group will continue to follow developments in this area, and, where appropriate, supplement its conclusions and recommendations.

Richard K. Willard
Chairman
Tort Policy Working Group

Robert L. Willmore
Chairman
Task Force on Liability
Insurance Availability

February, 1986

CHAPTER 1

THE CRISIS IN INSURANCE AVAILABILITY AND AFFORDABILITY

Liability insurance is a linchpin in the operation of the United States economy, yet many American businesses, professionals and municipalities, both large and small, are encountering serious insurance problems arising from premium increases, policy cancellations and refusals to underwrite certain activities.

The liability insurance crisis has three separate but related faces that individually or in various combinations make it difficult for many entities to obtain the desired liability insurance. These problems are availability of insurance, affordability of insurance coverage and adequacy of coverage.

This Chapter describes the current nature and extent of these problems. The Chapter focuses, first, on the problems encountered within the various lines of insurance, and, second, on the effect of those problems on different sectors of the economy.

I. INSURANCE COVERAGE SUMMARIES

The following are insurance summaries taken predominantly from insurance industry reports prepared by the Alliance of American Insurers or published in Business Insurance.

Environmental Impairment Liability Insurance ("EIL")

EIL covers pollution incidents stemming from gradual pollution exposures (as opposed to "sudden and accidental" pollution, which traditionally has been covered under general liability coverage). Two major companies dropped out of the market in 1985, and by the end of the year only two companies were offering EIL coverage. Forty-seven companies were forced to close hazardous-waste management facilities for lack of EIL coverage. Most hazardous waste businesses currently are looking toward captives and self-insurance. Brokers expect significant price increases on the limited insurance still available.

Sudden and Accidental Pollution Coverage

Coverage for sudden and accidental pollution traditionally has been provided as part of general liability coverage. New general liability forms, however, specifically exclude all pollution liability. This is due to court decisions interpreting "sudden and accidental" coverage as also covering gradual and intentional pollution. (See Chapter 3 for a discussion of the new policy forms.) The London market currently is excluding pollution coverage from the large risks it insures.

Directors and Officers Liability ("D & O")

Premiums in 1985 rose 50% to 500%, and include larger deductibles, lower limits, more restrictive endorsements and shorter policy durations. Industries particularly affected include financial institutions, electric (nuclear) utilities, new high technology business, wildcat oil and gas companies, research and development enterprises, real estate developers, highly leveraged businesses, petrochemical companies and the steel industry. Capacity constrictions have hurt larger risks more than smaller risks. Traditional primary and reinsurance capacity has been reduced, but Lloyd's of London, which has in the past not been active in this line, is offering primary coverage up to $20 million. Not surprisingly, business with Lloyd's of London is up to 100% to 200%. Much of the reinsurance market for such coverage has virtually dried up.

Bank Fidelity Bond Coverage

Premiums are up about 300%. A group of fifty banks are creating a mutual insurer to provide D & O and bankers blanket bond coverage.

Motor Carrier Liability Coverage

Bus and trucking companies are having severe difficulties obtaining the insurance coverage required by federal law. The Motor Carrier Act of 1980 requires insurance minimums of from $750,000 for carriers of non-hazardous cargo to $5 million for carriers of hazardous waste and most hazardous materials carried in bulk. The Bus Regulatory Reform Act of 1982 set insurance minimums from $1.5 million to $5 million, depending on the passenger capacity of the bus. Capacity is limited both in the primary and reinsurance markets. Small trucking firms and independent owner-operators have the most difficulty getting insurance.

Liquor Liability Coverage

Liquor liability coverage may be available as part of a commercial lines package, but is severely constrained and virtually nonexistent in some parts of the country as monoline coverage. This line has been affected by the bankruptcy of one of the largest dram shop insurers, Ideal Mutual Insurance Company.

Medical Malpractice Insurance

Availability problems are being encountered by nurse/midwives, obstetricians/gynecologists, pediatricians and dentists. Premiums are being raised and coverage limits are being reduced, sometimes by as much as 50%. Reinsurers are also restricting coverage in this line. St. Paul's Insurance Company, the largest medical malpractice insurer, has placed a moratorium on new policies. St. Paul's writes coverage for approximately 20%

of the Nation's doctors, and wrote an estimated $600 million in malpractice business in 1985. It had a pure loss ratio (excluding loss adjustment expenses and operating expenses) of 81.3% in 1984. Doctor-owned mutual insurance companies account for more than half of the medical liability coverage in the country.

Commercial General Liability ("CGL")

Commercial general liability insurance has undergone significant premium increases. The Insurance Services Office ("ISO"), the property-casualty insurers' statistical and ratemaking organization, has filed a new CGL form which will limit coverage and which contains certain exclusions and policy limitations (see Chapter 3).

Excess Coverage

Excess coverage capacity has been sharply reduced. This coverage currently is offered primarily on a claims-made basis, which may or may not mesh with the primary, reinsurance and other excess layers.

Reinsurance

Reinsurance capacity for the United States market has been severely limited, particularly with regard to Lloyd's of London, which has faced both its own problems and a disillusionment with the American market. This capacity problem is expected to ease somewhat in 1986, but is likely to remain a problem for some time longer.

II. SECTORAL SUMMARIES

The following are summaries of the effect of the insurance availability/affordability crisis on various sectors of the United States economy. This information was obtained from surveys conducted by business groups, articles in the trade press and materials prepared by trade associations or provided by industry representatives. While the following does not include all of the available information, it summarizes the major findings.

Municipalities

Municipalities are among the hardest hit groups by both affordability and availability problems. Local officials preparing their budgets for the next fiscal year report that the market for public entities is "extremely limited" and "diminishing to nothing." Those cities able to secure bids are finding insurance companies' offers prohibitively expensive. Renewal rates have climbed by as much as 400% -- and often for lower coverages with higher deductibles. Some cities are facing premium increases of up to 1,000%.

The United States Conference of Mayors conducted a survey of 39 cities in the summer of 1985. Over half the cities were quoted premium increases of over 100%, and 16 were quoted increases greater than 200%. In addition, a recent report by the Wyatt Company, Public Officials Liability Insurance: Understanding the Market (1986), notes that local governments have reported premium increases of 200% to 300% in the insurance purchased for their officials.

Rather than renew, many cities have decided to "go bare." All cities have been forced to reevaluate and sometimes limit the services they provide their communities. Finally, in the wake of policy cancellations, a number of city and county officials have resigned, fearing personal exposure to lawsuits stemming from their official duties.

Transportation

The American Public Transit Association, the nation's largest organization of transit operators, reports that premiums for those companies able to obtain insurance this year have gone up 500% to 1,000%, and sometimes more. In Los Angeles, the Southern California Rapid Transit District's annual premium jumped from $67,000 to $1.7 million, while coverage was reduced. Transit problems were compounded by the bankruptcy of one of the largest companies involved in insuring mass transit systems. Some local transit systems have had to suspend operations.

Publishing

Newspaper and magazine publishers are finding it more difficult to obtain libel insurance.

Nurse-Midwives

The American College of Nurse-Midwives represents 2,500 members, 1,400 of whom were covered under a blanket policy through the association. The policy was cancelled on July 1, 1985. The association has been unable to obtain other coverage and has been attempting to create a captive insurer. The captive was to have started operation by April 1, 1986, but that deadline will not be met.

Grocers

A survey by the National Grocers Association found that its members' liability insurance premium rates had recently increased from 25% to 500%. The survey covered 161 retailers and 20 wholesalers.

Architects and Engineers

Most architectural and engineering firms, and particularly smaller firms, are experiencing severe availability and affordability problems. Insurance premium rate increases of

200% to 300% have become the norm. Roughly 30% to 40% of smaller firms are going bare. Engineering firms involved in asbestos or other toxic substances abatement activities face extreme difficulties in obtaining insurance, with rate increases, where insurance is available, of 5,000% not uncommon.

Day Care Centers

The National Association for Education of Young Children conducted a survey of day care providers. They covered family day care providers who care for children in a home setting, day care centers and headstart programs. The survey found that 40% of the respondents had had their insurance cancelled or not renewed and the majority of those with coverage had premium increases, most of which rose 200% to 300%.

Toy Manufacturers

The Toy Manufacturers of America recently surveyed its 243 members on insurance cost and availability problems. Final results will not be available until April, but initial responses are:

Members	%Increase in premiums
21	50
9	50-100
12	100-150
2	150-200
11	300-500
7	500-1000
1	over-1000
2	cannot obtain insurance

Companies that normally had three to four months to negotiate a policy renewal have been given only 72 hours to do so this year. This permits insufficient time for policy shopping. The association reports that it had recommended a captive to its members a few years ago. Commercial insurers reduced prices upon learning of the proposal, eliminating industry interest in a captive.

Household Appliance Manufacturers

The household appliance industry has seen sharp reductions in available coverage, and the Association of Home Appliance Manufacturers has lost group coverage it had arranged in 1983. Many companies have been able to obtain only about one-third of the coverage sought for product liability, and the cost of that coverage is increasing. Member companies are having similar problems obtaining D & O insurance.

Automobile Repair

The Automotive Services Councils, an association representing automobile repair shops and garages, conducted a survey with 104 responses. Average premium increases were 70% to 80%. Some 13% of the membership reported purchasing an average of 30% less coverage. Approximately 41% had experienced policy cancellations and 26% were unable to find new carriers.

Medical Equipment

The medical equipment industry has had a captive, MedMarc, an affiliate of the Health Industry Manufacturers Association, since 1979. The captive started with 35 companies and has recently reached 100 member companies. The rate of growth increased in 1985 as the result of cancellations by commercial insurers of about 20% of the Association's members and premium increases of five to ten-fold.

Biotechnology

Biotechnology companies are having a particularly difficult time in the tight market because they are generally new, small companies dealing mostly in research and development in a field largely unknown to insurers. Their inability to obtain coverage causes them difficulty in obtaining bank financing, which, in turn, causes some of these companies to sell out or forego promising research. The industry is exploring the creation of a captive.

Oil and Gas Drilling

The International Association of Drilling Contractors represents 1,500 contractors operating drilling rigs. It estimates maritime liability premium increases of 300% to 700% and inland liability premium increases of 100% to 150%.

Construction Contractors

Constructor magazine (October 1985) estimates average increases in general liability coverage of 40% to 75%. For contractors who were able to negotiate significant discounts in past years increases currently are running up to 300%. In 1985 premium increases for umbrella coverage were approximately 300% for less coverage.

Natural Gas Transportation

The National L-P Gas Association represents 4,100 firms that prepare and transport liquefied petroleum gases for residential and industrial users. According to a spokesman, as many as 25% of the transporters are operating with less than the $5 million in insurance coverage that is required of motor carriers by federal law. Difficulties are attributed to unavailability and prohibitive costs of umbrella insurance.

General Manufacturing

The Machinery & Allied Products Institute ("MAPI") recently conducted a survey of 81 companies producing a broad range of products in the manufacturing industries and obtained an 80% response rate. The typical respondent experienced increases for every type of insurance covered in the survey. The survey covered general liability, D & O, environmental impairment liability, products and other property and casualty coverages. The size of the increases varied with the date of the renewal; consequently, the survey results understate the problem since many of the respondents are not up for renewal until early this year. Significant survey results are shown in the table below.

MAPI Survey Results on Liability Coverages

Premiums	% Higher	% Change (Median)
CGL-Primary	73	40
CGL-Excess	100	250
D & O	72	300
EIL	94	60
Products	95	116
Other	87	40

Lower Limits	% Lower	% Change (Median)
CGL-Primary	13	-36
CGL-Excess	66	-50
D & O	27	-25
EIL	59	-50
Products	33	-50
Other	18	-25

Deductibles & Exclusions	% Higher Deductible	% More Exclusions
GCL-Primary	34	97
GCL-Excess	25	96
D & O	49	95
EIL	50	89
Products	50	100
Other	28	100

In addition to the foregoing, 35% of the MAPI respondents indicated that their general liability coverage excluded "sudden and accidental" pollution coverage, while 49% indicated that it was excluded in some layers and included in others. Some 65% of the respondents indicated that they had some coverages cancelled since January 1, 1985.

Machine Tool Manufacturers

The National Machine Tool Association represents 300 to 400 businesses that manufacture heavy machinery which cuts, shapes and forms metal. Preliminary results of a survey indicated product liability premiums have doubled since 1984, and that about half of the respondents have been or expect to be put on claims-made policy forms.

Battery Recycling & Smelting Companies

Battery recycling companies are typical of many industries where processes create toxic wastes. Recycling 50 million scrap batteries accounts for up to 50% of the annual lead smelter production. If the batteries are not recycled, they will be disposed of in landfills, leading to more serious toxic exposure. One major smelting company was offered a $10 million policy with a $2.5 million deductible at a cost of $650,000. While it deems the policy uneconomic, it has not found an alternative. The problem is widespread with smelters of various metals. The uncertainty of the risk and size of pollution liabilities has lead to substantial reductions in coverage with sharp increases in deductibles and premiums.

Power Equipment Manufacturers

Outdoor power equipment manufacturers had been reporting premium increases of from 50% to 70% during the past year. At the end of the year, with many renewals coming due, some have experienced increases of 400% to 600%. The Association once again is considering establishment of a captive.

General Aviation Manufacturers

The General Aviation Manufacturers Association reports that the cost of liability insurance per aircaft was $51 for the 6,778 business, commuter and private aircraft delivered in 1962, and increased to $211 for the 9,774 delivered in 1972. Currently, for the 2,000 planes delivered in 1985, the liability insurance cost has increased to $70,000 per plane. The cost of liability insurance to air frame manufacturers in 1985 was about $135 million, with a total cost of $175 to $200 million for the entire industry that includes manufacturers of engines, electronics and parts.

Ski Operators

Liability insurance premium increases of up to 400% have been reported by the National Ski Areas Association. Some small ski areas have closed, and the average price of lift tickets has increased substantially.

Aerospace Equipment Manufacturers

Aerospace equipment manufacturers are increasingly concerned that the escalating cost of product liability insurance and other associated costs are causing them to lose their ability to compete with overseas manufacturers of similar equipment.

III. THE NATURE AND EXTENT OF THE INSURANCE AVAILABILITY/AFFORDABILITY CRISIS

The above examples of insurance availability, affordability and adequacy problems demonstrate the broad scope of the liability insurance crisis in the mid-1980's. In a similar crisis in the mid-1970's, the problem areas were largely confined to medical malpractice and product liability. Medical malpractice coverage has been a continuing problem, with almost half that coverage currently underwritten by doctors' and hospitals' mutuals and other alternative markets. Product liability coverage, however, was readily available at declining cost during the late 1970's and early 1980's.

A growing capacity shortage over the last year or more has caused commercial insurers to review carefully their underwriting standards and pricing policies in order to determine where insurance capacity can be utilized most profitably. The inevitable result of this reevaluation has been a severe disruption for insurance buyers.

Insurance Availability

Availability problems are occurring in certain specialty commercial insurance markets. These include pollution, day care, municipal, liquor, motor carrier and D & O liability coverages. The bankruptcies of some specialty insurers, particularly in the lines of motor carrier and liquor liability, have affected the capacity in these coverages.

In each of these lines, insurers have perceived the possibility of significant losses based on highly publicized verdicts and settlements. General line insurers who ordinarily would fill the gap left by specialty carriers are unwilling to do so because they can use their scarcer dollars in less volatile and more profitable lines.

Insurance Affordability

Premiums are increasing in virtually all commercial coverages. Examples of affordability problems include nurse-midwives and general aviation manufacturers, both of which face premium costs which may be warranted by the experience, but are too expensive for the buyers. Solutions to problems like these appear to lie outside of the insurance system.

Insurance Adequacy

Problems of insurance adequacy are being experienced across all commercial lines of coverage. The main problem seems to lie with the fact that many buyers are unable to buy as much insurance as they desire. This is particularly true for large firms which seek large amounts of excess and higher limits coverage. These problems appear related in part to a capacity crunch created both by the insurance cycle and the withdrawal of capacity by the overseas reinsurers. The lack of capacity related to the insurance cycle shows signs of abating as the corner of the cycle has turned and surplus is increasing. But many firms may have to use alternative market mechanisms for at least a couple of years until this capacity fully returns. It may take much longer to get reentry by overseas reinsurers who have grave concerns about the American tort liability system. A second area of inadequacy lies in the growth of exclusions, deductibles and other policy limitations that are just now being introduced into the market. These are discussed in Chapter 3.

The Insurance Availability/Affordability Crisis

Finally, it should be noted that the crisis in insurance availability and affordability does not appear to be a crisis for the insurance industry. While the industry (as discussed in Chapter 2) is suffering substantial underwriting losses, the Working Group does not perceive this crisis to be a major threat to the financial viability of the industry. Rather, it is a crisis for the insureds who cannot obtain or afford the insurance they believe necessary for their on-going activities. And, to the extent that entities are forced to operate without insurance or with inadequate insurance, it is a crisis for victims of tortious conduct who may find that liable defendants cannot pay them their damages.

CHAPTER 2

THE CAUSES OF THE CRISIS IN INSURANCE AVAILABILITY AND AFFORDABILITY

A number of reasons have been proffered for the crisis in the availability, affordability and adequacy of liability insurance. Many of these reasons relate to the economic decisions and performance of the insurance industry over the past decade. Other reasons focus on recent developments in tort law. While the two in fact are closely related, this Chapter discusses each of these areas separately. Part A deals with the general economic reasons for the current crisis; Part B reviews the contribution of tort law. [1]

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[1] There have been suggestions that the availability/affordability crisis may be caused by certain aspects of state regulation. While some regulatory measures may have aggravated the problem, the Working Group has found little compelling evidence that the crisis is the result of a regulatory failure, either in the sense of insufficient or inadequate regulation, or in the sense of ill-conceived regulation. In this regard, it is worthwhile noting the 1977 report of the Department of Justice to the Task Group on Antitrust Immunities on The Pricing and Marketing of Insurance, which concluded that "in the commercial lines . . . state regulatory schemes are largely illusory and that insurers are generally free to set their own prices." Id., at vii. The report further indicated that rigid state rate regulation, such as is found in automobile insurance, may in fact aggravate an availability problem. Id., at vi.

In this regard, it is worth noting the conclusion of the Medical Malpractice Policy Guidebook (1985), prepared by Henry Manne (general editor) and Barry Anderson, Patricia Danzon, Clark Havighurst, Charles Phelps and Frank Sloan (principal authors) for the Florida Medical Association. The Guidebook concluded that it was difficult to fault the state insurance regulatory system for the high medical malpractice insurance premiums in Florida. Id., at 11. The report concluded that premium increases lag claims costs, and that "malpractice premiums are almost certainly not 'too high' compared to the increases in claims costs emerging over recent years." Id., at 149-50.

Some have pointed to state insurance reserve requirements as a cause of the insurance availability/affordability crisis, to the extent that they believe these requirements to have exacerbated capacity constraints. While the Working Group did not analyze whether state reserve requirements are too high or too low, it should be noted that these requirements exist to ensure the solvency of insurance carriers, and thereby to protect insureds. It also should be noted that the only way that state insurance reserve requirements conceivably could be modified to

(CONTINUED)

A.

I. INSURANCE INDUSTRY PERFORMANCE

Recent news accounts have presented a seemingly conflicting view of the economic performance of the property-casualty insurance industry. In order to understand the financial condition of the industry itself and of some of its specific lines of business, it is useful to compare the condition of the industry as a whole to what has been happening to premiums in the lines which present significant availability/affordability problems.

The table below presents premium and loss data for the property-casualty insurance industry for the period 1981 through 1985.

Year	Net Premiums Written (000)	Loss and LAE (000)	Expenses (000)	Statutory Underwriting Loss after Policyholder Dividends (000)
1981	$ 98,805,725	$75,764,229	$27,132,052	$- 6,323,534
1982	103,115,653	82.152,241	28,996,122	-10,415,751
1983	107,802,698	87,719,055	30,799,231	-13,285,049
1984	117,743,957	103,720,652	32,980,082	-21,455,300
1985*	142,300,000	126,846,220	37,353,750	-25,200,000

*Estimated

Source: Best's Insurance Management Reports

The most striking number in the table, of course, is the $25 billion underwriting loss estimated for 1985. This number represents the difference between premiums written and expenses, policyholder

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1/ (FOOTNOTE CONTINUED)

produce lower premiums would be if the reserve requirements were relaxed. It would be difficult to justify relaxing reserve requirements, however, in light of the fact that both insurance company insolvencies and the number of insurance companies reported to be in financial difficulty have increased substantially in the last two years.

The Working Group is continuing to review the contribution, if any, of state regulation to the insurance availability/affordability crisis.

dividends, 2/ estimated losses and loss adjustment expenses ("LAE").

The underwriting loss, however, while significant, represents only part of the industry's overall financial picture. Since premiums are collected well in advance of any anticipated payout, they are invested and earn income. In addition, other income is generated which also must be considered in reviewing the industry's financial condition. Overall income in 1985 resulted in the industry showing a $7.6 billion gain in policyholders' surplus (the equivalent of net worth), 3/ on an underwriting loss of $25.2 billion and net investment and other income of $32.8 billion. Thus, the industry appears to have made an overall profit in 1985, though at a lower rate than historical levels or other sectors of the economy.

In discussing the overall financial review of the property/casualty industry, Best's reported that:

> Investor interest in the property-casualty industry cannot be denied. While the Dow Industrial Average had made headlines by surpassing the 1500 mark (a 25% gain for the year), Best's Index of property/casualty companies has jumped 50% at this writing, and security analysts specializing in insurance--and cognizant of 1985's underwriting losses--nevertheless continue to be optimistic about the industry's prospects. 4/

Two factors must be taken into account in assessing the role of the insurance industry's financial performance in the insurance availability/affordability crisis. First, even though the industry currently is making a profit, that profit is well below the profitability of most other major industries, as well as the insurance industry's historical average. For example, in 1984 the property-casualty insurance industry produced an annual rate

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2/ Questions have been raised as to whether or not the $2.1 billion paid out in policyholder dividends should be included in the underwriting loss. Policyholder dividends are offered to some policyholders in some lines, and reduce the net cost of their insurance coverage. Consequently, any reduction in such premiums simply increases the net cost to policyholders.

3/ Policyholders' surplus is the difference between insurers' assets and liabilities. It is considered "the financial security that stands behind every insurance policy and is that which provides the cushion to support the shock of major catastrophe, stock market declines and loss of reserve inadequacies." ISO, Financial Condition of the Insurance Industry -- An Update (1985).

4/ Best's Insurance Management Reports (December 30, 1985).

of return on net income after taxes as a percent of net worth of 1.8%, whereas the median for Fortune 500 companies was 13.6%. 5/ The comparable rate of return for the property-casualty insurance industry from 1975 to 1984 was 10.9%. 6/

Second, the insurance availability/affordability crisis has not manifested itself across the entire spectrum of insurance services, but only in specific lines. These lines account for a relatively small portion of the industry. For example, the entire property-casualty insurance market accounts for only approximately one-third of the overall insurance market in terms of written premiums. 7/ The two property-casualty lines that have been the primary source of availability/affordability problems -- general commercial liability and medical malpractice -- amounted to only 7% of all the property-casualty lines in terms of 1984 written premiums. 8/ (These two lines thus represent approximately 2.5% of the entire industry's written premiums in 1984.) But, as can be seen in Subsection II, about one-fifth of the property-casualty industry's $21.5 billion 1984 underwriting loss came from these two lines. And in 1985, the two lines accounted for almost one-quarter of the property-casualty industry's estimated $25.2 billion underwriting loss. These two lines, as well as the Commercial Multiple Peril line, 9/ are discussed in greater detail in Subsection II.

II. UNDERWRITING RESULTS BY MAJOR LINES

While the industry overall has been profitable, certain lines have made major contributions to the underwriting losses. This section examines the major commercial lines in which availability and affordability problems have been most prominent.

Commercial Multiple Peril

Commercial Multiple Peril ("CMP") is related to the general liability line of insurance in that it is a packaged line of business which includes some commercial general liability coverage and its long-tail losses; that is, losses which may be

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5/ Insurance Information Institute, 1985-86 Property/Casualty Factbook, page 22.

6/ Id. The comparable statutory accounting rate of return was 11.9%. Id.

7/ Congressional Quarterly Weekly Report, page 150 (January 25, 1986).

8/ Insurance Information Institute, 1985-86 Property/Casualty Factbook, page 16.

9/ If the Commercial Multiple Peril line is taken into account, approximately 14% of the property-casualty industry (in terms of 19 written premiums) accounted for about one-third of its underwriting losses in both 1984 and 1985. Id.

reported many years after the policy year. CMP experience over the past five years is reflected in the chart below.

Commercial Multiple Peril

Year	Net Premiums Written (Billions)	Loss and LAE (Billions)	Underwriting Expenses (Billions)	Statutory Under-Writing Loss After Policyholder Dividends (Billions)
1981	$6.8	$4.6	$2.5	$-0.5
1982	6.9	5.3	2.7	-1.2
1983	7.2	5.9	2.9	-1.7
1984	8.2	7.9	3.2	-2.9
1985*	11.7	10.4	4.1	-3.0

*Estimated

Source: Best's Insurance Management Reports 12/30/85

While the underwriting losses for CMP rose to $3 billion in 1985, it is readily apparent that until recently there had been little premium growth in the line. Best's predicts that the short-tail, non-liability portion of CMP should provide the ability for a fast turnaround for this line. It also notes that ISO's new CGL claims-made form will be added to the standard CMP form, but that market pressures should assure the availability and affordability of the smaller businessowner's package. 10/

Commercial General Liability

Commercial General Liability ("CGL") coverage includes most of the commercial sectors which are experiencing serious availability/affordability problems. It covers product liability, municipalities, day care centers and other commercial coverages. It is the line for which ISO has introduced its new claims-made form. The experience of this line over the past five years is summarized below.

General Liability

Year	Net Premiums Written (Billions)	Loss and LAE (Billions)	Underwriting Expenses (Billions)	Statutory Under-Writing Loss After Policyholder Dividends (Billions)
1981	$6.0	$5.1	$1.8	$-1.0
1982	5.6	5.4	1.8	-1.7
1983	5.7	6.0	1.8	-2.1
1984	6.5	7.8	1.9	-3.2
1985*	11.1	13.2	2.7	-4.6

*Estimated

Source: Best's Insurance Management Report

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10 Best's Insurance Management Reports (December 30, 1985).

As is apparent, written premiums dropped in 1982 and 1983 and rose slightly in 1984. The figures for 1985, however, show a dramatic increase of 72% over the 1984 premium. Increases are continuing to occur in the line as policies come up for renewal. Losses increased throughout the period, but did so at a relatively even pace until 1984, when losses increased by over $1 billion dollars over the previous year's losses.

Medical Malpractice

Medical malpractice represents only about 1.8% of property/casualty insurance written, but has been the source of major availability/affordability problems. The following chart summarizes the experience of the line over the past five years.

Medical Malpractice

Year	Net Premiums Written (Billions)	Loss and LAE (Billions)	Under-writing Expenses (Billions)	Statutory Under-writing Loss After Policyholder Dividends (Billions)
1981	$1.3	$1.6	$0.2	$-0.5
1982	1.5	2.0	0.2	-0.7
1983	1.6	2.1	0.2	-0.8
1984	1.8	2.8	0.3	-1.1
1985*	2.6	3.6	0.3	-1.4

*Estimated

Source: Best's Insurance Management Report

Medical malpractice experience is receiving considerable attention at the state level. Unlike many lines of coverage such as product liability, rates are based on state claims rather than national data.

III. PREMIUM TRENDS

The recent rapid growth in premiums has been a major element in the current availability/affordability crisis. This section examines this trend. The following data was provided by the ISO.

Cash-flow underwriting is generally acknowledged to have played a role in causing the large underwriting losses presently being experienced in the commercial lines. According to ISO, the industry's current underwriting losses are a result of "a prolonged period of underpricing and rapidly expanding tort liabilities." 11/ In this regard, the ISO report states:

> For the better part of seven years, the insurance industry has been engaged in a brutal price war. During the early 1980's, the price for commercial insurance was decreasing, sometimes sharply, as insurers vied for premium dollars to invest at the high interest rates then in effect. At the time, commercial customers did not complain. Indeed, many realized that commercial insurance in the United States was being sold below cost, even when investment income was considered. 12/

Chart A, based on ISO data, tracks commercial line premiums in constant 1967 dollars. As can be noted from the chart, 1984 marked the first real increase in premiums (in constant dollars) after five consecutive years of declining written premiums. But 1984 written premiums were almost 20% less than premiums collected in 1978, the year preceding the dramatic decline in premiums. At the same time, losses and expenses in 1984 were at an all-time high. 13/

A similar comparison of the general liability premiums written, premiums earned and line outgo over the past ten years (not in constant dollars) is shown in Chart B.

Analyzing this data, the Best's report notes that during the relevant period (1975 - 1985):

> . . . the inflation of liability awards could have been no secret to any underwriter. Had the ascending line of premiums written that was established in 1975 through 1978 continued to rise, the general liability losses of $13 billion incurred in the last six years largely would have been avoided. 14/

11/ ISO, Financial Condition of the Insurance Industry -- An Update (1985).

12/ Id.

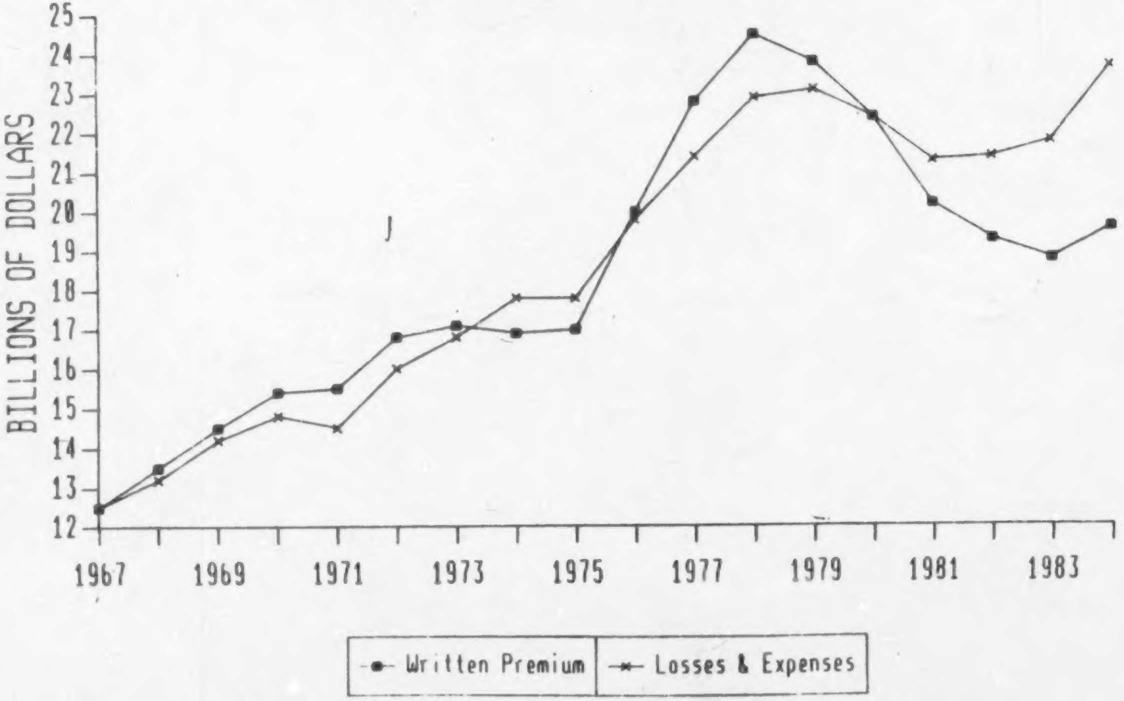
13/ Id.

14/ Best's Insurance Management Reports (December 30, 1985).

CHART A

WRITTEN PREMIUM vs. LOSSES & EXPENSES

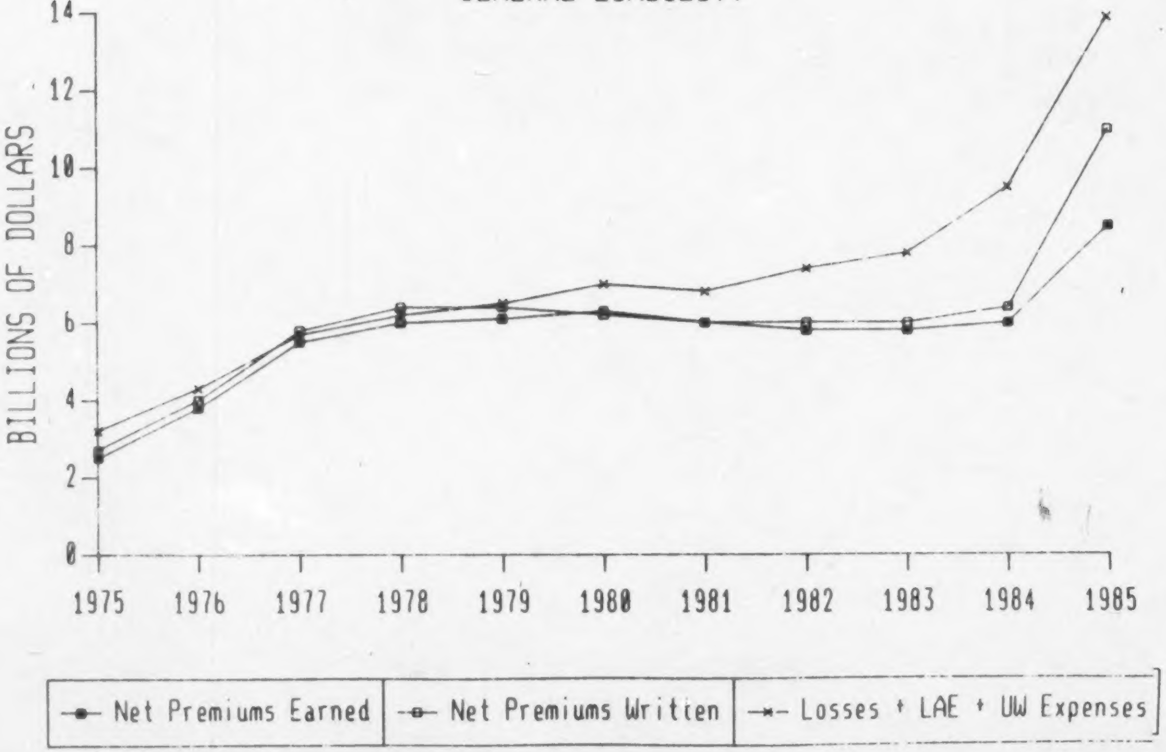
COMMERCIAL LINES IN CONSTANT 1967 DOLLARS



Source: Insurance Services Office

CHART B

GENERAL LIABILITY



Source: Best's Insurance Management Report, 12/30/85

IV. THE ECONOMIC CAUSES OF THE INSURANCE AVAILABILITY/AFFORDABILITY CRISIS

The above discussion indicates that during the late 1970's and early 1980's the insurance industry engaged in significant premium reductions while claim losses increased steadily. The result, not surprisingly, has been massive underwriting losses in recent years.

It is useful in considering the contribution of such economic factors to the insurance availability/affordability crisis to distinquish two different effects which frequently are confused. The first is the inflationary effect on premiums of the recent decline in interest rates. The second is the premium cutting which took place in the late 1970's and early 1980's as a consequence of the industry's desire to take advantage of high interest rates available during that period.

As to the first effect, there is an obvious inverse relationship between premiums and the prevailing interest rate. A significant portion of an insurer's profits stem from the return on the premium income it invests between receipt of the premium and payout of the incurred liabilities. When interest rates are high, premiums tend to be lower since more of the insurer's income comes from such return on investment; and when interest rates are low, premiums will tend to be higher since the insurer is more dependent on the premium principal to cover the anticipated payout. Thus, as interest rates fall -- as they have in the mid-1980's -- insurance premiums inevitably increase.

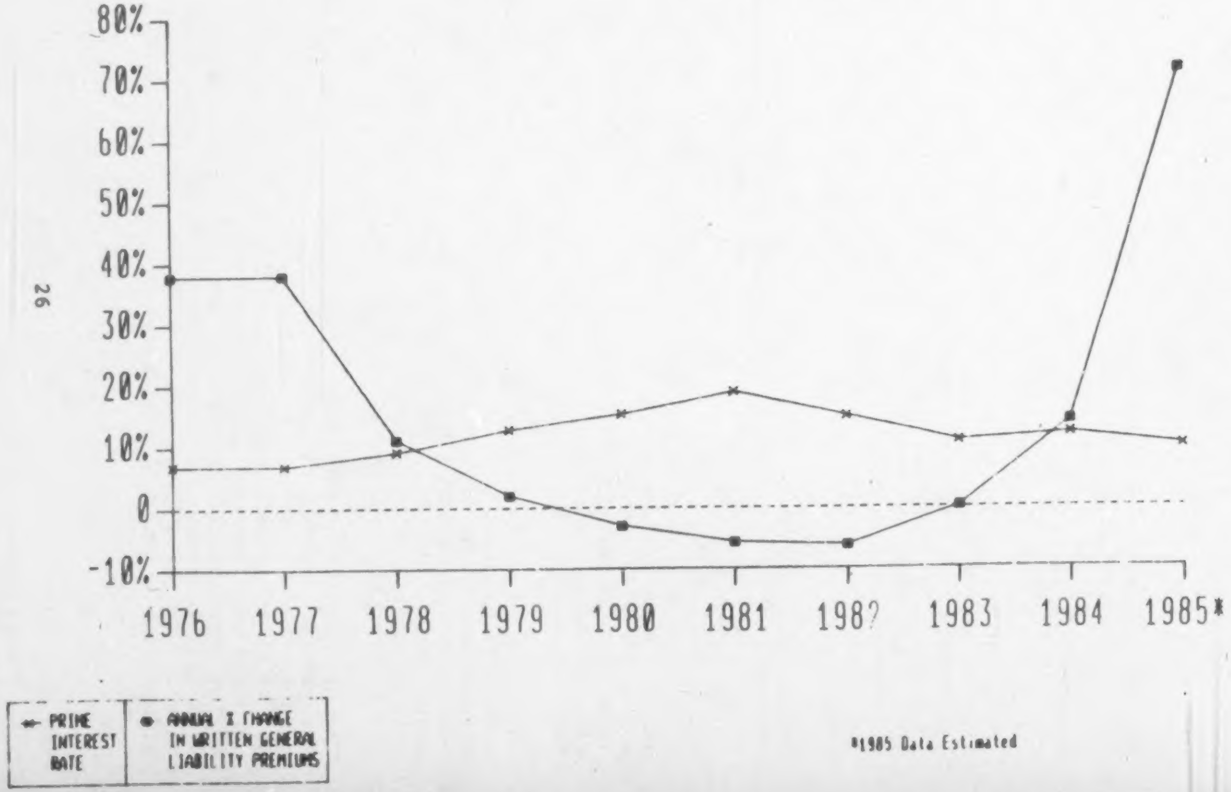
This inverse relationship is illustrated by Chart C, which compares the prime rate in 1976 through 1985 to the annual percentage change of the total Commercial General Liability (CGL) premiums written by the insurance industry in each of those years. 15/ Chart C graphically demonstrates that the rate of growth of the written premiums changes inversely with the movement of the prime interest rate.

To the extent that the recent sharp premium increases are related to the drop in interest rates, there is little the federal (or any) government can or should do to mitigate this market effect. Declining interest rates cause innumerable economic realignments which, on the whole, are quite beneficial to the economy. An increase in insurance premiums resulting from such a reduction in interest rates, while of itself undesirable, is a relatively minor side effect to the far more significant economic consequences of a drop in the interest rate.

15/ The percentage change in 1976 through 1984 is obtained from the Insurance Information Institute's most recent Property/Casualty Factbook. The estimate for 1985 is obtained from the ISO data discussed *supra*.

CHART C

PERCENTAGE CHANGE IN GCL PREMIUMS COMPARED TO INTEREST RATE



*1985 Data Estimated

Moreover, there is little that can be done to address this source of premium volatility. It would be absurd to try to keep interest rates high simply to keep insurance premiums as low as possible. But as long as interest rates fluctuate, premiums necessarily will reflect such changes.

A second economic factor related to interest rates is the extent to which high interest rates may have triggered "excessive competition" in the insurance industry which led the industry to sell its product too cheaply. For one thing, even assuming one accepts the concept of "excessive competition," it is unclear how such losses in fact contribute to the insurance availability/affordability crisis. As discussed later in this Chapter, such losses are "sunk costs" which the industry cannot recoup simply by charging higher premiums. If premiums in fact are higher than the insured risks and the currently available investment return dictate, either other sources of capital (including insurers who have suffered no losses or lower losses) should offer the same insurance at a lower price, or insureds will retain these "excess profits" for themselves through self-insurance or the formation of captives. The fact that there appears to be little insurance coverage being made available by new or expanding underwriters, and that many insureds are highly reluctant to self insure or form captives (even though many with serious availability problems may have no alternative), strongly indicates that recoupment of losses is not a particularly compelling explanation for the current insurance availability/affordability crisis.

It is particularly puzzling that the proponents of this theory advocate the abolition of the insurance industry's antitrust immunity contained in the McCarran-Ferguson Act (Public Law 79-15) as an appropriate response to the asserted problem of the industry's cash-flow "mismanagement." It is hard to reconcile the argument that the current problems of the insurance industry stem from "excessive competition" with the proffered solution of removing the industry's antitrust immunity. Since the goal of antitrust law is to enhance competition, if one truly believes that the problems of the insurance industry are a result of too much competition, the last thing one would advocate is a legal change which would increase the level of competition. While the Working Group did not review and takes no position on the continuing validity of the industry's antitrust immunity, 16/ it is readily obvious that the suggestion that allegedly "excessive competition" can be cured by even more competition is patently absurd.

16/ Despite the assertions of some, the Working Group found no evidence to suggest that the industry's antitrust immunity is a significant factor in the insurance availability/affordability crisis. It should be noted, however, that the immunity has been criticized ~~for~~ a variety of other reasons. See the 1977 report of the Task Force on Antitrust Immunities, footnote 1, *supra*.

The reasons why the loss recoupment (or excessive pricing) theories advocated by some make little economic sense can briefly be summarized as follows:

- Insurers, like all profit maximizing companies, charge the price which maximizes their profits. Past gains or past losses are irrelevant to setting the price today which will maximize profits tomorrow. The argument that insurers are charging higher premiums to recoup past losses suggests that absent such losses their premiums would be lower -- that is, that they would not be charging premiums that maximize their profits. That makes little sense.

- Even if excessive premiums were being charged by some insurers to recoup their past losses, for the reasons discussed, other insurers would offer the same coverage at lower prices reflecting the actual risk, or insureds would retain such excess profits for themselves through self-insurance or the formation of captives. 17/

- The commercial lines of insurance, which are at the center of the availability/affordability crisis, in fact are relatively competitive. For example, the 1977 report of the Task Force on Antitrust Immunities (see footnote 1, supra) found that the property-liability insurance industry "appears to possess an atomistic market structure," including over 900 companies. Id., at 7. 18/ The Task Force also found that the restrictions to entry do not appear significant in the property-liability insurance industry, id., at 9, and that there appears to be price competition in this line as a result of "an industry structure that favors competition." Id., at 27-28. 19/ It is, of course,

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17/ Many insurance companies are mutuals, meaning that they are owned by their policyholders. The suggestion that they are charging their policyholder-owners unnecessarily high premiums makes even less sense, since any such excess profits must be rebated through policyholder dividends.

18/ The report states that 20 insurance groups account for 53% of written premiums, and that no single group accounts for a major share of the market. Id., at 8. This is consistent with the analysis of the Medical Malpractice Policy Guidebook (H. Manne, 1985), which found the medical malpractice insurance market in Florida to be "substantially and effectively competitive." Id., at 166.

19/ See also page 348 of the report summarizing the Task Force's (CONTINUED) difficult to conceive how premiums are being kept at artificially high levels for a line of insurance in which prices appear to be competitively determined.

- Finally, many of the strongest proponents of the loss recoupment theory also contend that these losses were the result of excessive price competition in the industry. Obviously, it is difficult to reconcile these arguments. 20/

In sum, to the extent that purely economic factors underlie the insurance availability/ affordability crisis, they do not appear to be the type of problems which can be cured by different or more intensive forms of government regulation -- either at the state or federal level -- of the insurance industry. There, however, is a cause of the availability/ affordability crisis at the very heart of that crisis which the government is well placed to address in a variety of constructive ways. That cause is tort law, and its role in the crisis is discussed in Part B of this Chapter.

B.

The above discussion has focused largely on the current financial condition of the insurance industry, and the economic factors leading to that condition. The following discussion examines the state of tort law, and its central role in the insurance availability/affordability crisis.

Unlike the above related economic data on the insurance industry, it is difficult to obtain good empirical data indicating precisely what has happened to tort liability in

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19/ (FOOTNOTE CONTINUED)

conclusion that the "industry is structured in a manner conducive to competition." It should be noted that these conclusions did not appear to apply to some other lines of insurance such as life insurance.

20/ These same points apply equally well to arguments that premiums are set excessively high to recoup losses resulting from mismanaged investment portfolios. Just as past losses are irrelevant to determining the premiums which will maximize profits, investment portfolio losses should have no bearing on premiums. In this regard, however, it should be noted that the property-casualty industry made $32.8 billion from net investment and other income in 1985. See *supra*.

recent years. 21/ It is plain even to the most uninitiated that tort law has changed dramatically in recent years -- from a relatively quiescent legal backwater into one of the most important and dynamic areas of the law today. 22/ Moreover, a growing body of case examples and empirical data suggest that the current tort system has serious problems and is operating quite poorly. The insurance availability/affordability crisis is one symptom -- albeit the most dramatic and acute symptom -- of the dislocations and problems generated by a malfunctioning tort system.

I. PROBLEM AREAS IN TORT LAW

In attempting to understand what has happened to tort liability in the United States, the Working Group has focused on four interrelated areas: fault, causation, damages and transaction costs. Each is discussed separately below.

The Movement Toward No-Fault Liability

One of the most disturbing aspects of the current tort system is the degree to which it has moved toward no-fault liability. While this movement began in earnest over twenty years ago, it appears to have accelerated dramatically in recent years.

Beginning in the early to mid-1960's it became fashionable to reject the twin pillars upon which tort law historically had been constructed -- deterrence and compensation -- in favor of seemingly more enlightened theories based largely on concepts of societal insurance and risk spreading. 23/ While many of these

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21/ The Rand Corporation, through its Institute for Civil Justice, has produced the best empirical data and analyses available in the area. While the Institute has only been able to research discrete areas of civil justice, the conclusions drawn from those analyses are invaluable to understanding many broader problems. The recently published five-year overview of the Institute's program offers an excellent summary of the research, results and continuing work of the Institute's staff.

22/ For example, at the end of fiscal year 1975, what is now the Torts Branch of the United States Department of Justice contained 39 attorneys, who handled or supervised about 4,000 cases totalling approximately $1 billion in claims. At the end of fiscal year 1985, the Torts Branch had grown to 124 attorneys handling or supervising about 11,000 cases totalling approximately $200 billion in claims.

23/ One of the most explicit statements of such a theory can be found in the decision of the New Jersey Supreme Court in Beshada v. Johns-Manville Products Corp., 90 N.J. 191, 447 A.2d 539 (1982), in which the Court expressly denied defendants (CONTINUED) theories were couched in terms of economic efficiency, they represented the beginning of a devastating, and to this day, ongoing challenge to the role of fault as a predicate of tort liability. The long-term effect of this development has been less to promote a more efficient or sensible tort system, 24/ than to undermine the importance of fault (or wrongdoing) as a moral and doctrinal justification for and limitation on tort liability. As this limitation has been removed or undermined in certain areas of tort liability, tort law increasingly has come to rest only on the pillar of compensation, with compensation often awarded merely for the sake of compensation.

As the tort system moves away from fault it increasingly imposes liability upon persons and companies that have done nothing wrong. This has been accomplished in a variety of ways: by directly reducing or even eliminating the fault requirement; by

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23/ (FOOTNOTE CONTINUED)

the opportunity to raise a "state of the art" defense. The Court held that even if the danger at issue was scientifically unknowable at the relevant time, defendants nonetheless were still liable for having failed to warn of an unknowable risk. As justification for its holding, the Court relied heavily on risk spreading. In the words of the Court, "manufacturers and distributors . . . can insure against liability and incorporate the cost of the insurance in the price of the product." 447 A.2d at 547. The Court went on to opine that the likely increase in premiums to compensate for unanticipated risks was "not a bad result." Id.

24/ The belief that tort liability should be no-fault so as to serve as a risk spreading mechanism for all injuries is in fact quite anti-consumer. Such a view of tort liability effectively would mean that the price of every product and service would include an insurance surcharge for the risk of any injury related to the product or service. It has long been understood, however, that because of the extraordinarily high transaction costs of the tort system, such compulsory insurance through the tort system would be among the most inefficient and costly ways for consumers to purchase insurance. Thus, for every $1 of compensation, the tort system requires the consumer to pay approximately $3 in premiums (assuming, as discussed infra, two-thirds transaction costs), while that same $1 of compensation can be obtained through first-party health and disability insurance for only $1.25. H. Manne, Medical Malpractice Policy Guidebook 143 (1985). It is highly ironic that many proponents of no-fault liability argue that such liability is in the best interest of consumers. In fact, since consumers ultimately pay the premiums of whatever compensation scheme is devised, quite the contrary is the case. See also Epstein, "Products Liability as an Insurance Market," 14 J. Legal Stud. 645 (1985).

defining new duties that effectively create fault where no fault existed previously; and, by engaging in after-the-fact analyses that "find" fault wherever there has been an injury. 25/ The ultimate effect of these developments has been the same -- to shift liability for compensation to "deep pocket" defendants that have the resources to compensate plaintiffs generously. 26/

Fault has not, however, been openly (or completely) rejected as part of our tort law. One reason is that fault remains the only vehicle in tort law capable of distinguishing wrongful (or undesirable) from beneficial (or desirable) conduct. If fault were rejected altogether, it would mean that desirable activities would be just as likely to incur liability as wrongful conduct. An open rejection of fault thus necessarily would result in a sweeping transformation in the public's attitude toward tort law, which continues to be bottomed on the concept of tort liability as a form of justified redress for wrongful conduct. A second reason why fault continues to be part of tort law (and why courts often will engage in amazing distortions of relevant facts or legal doctrines to find fault rather than simply reject the principle of fault) is that fault is the basis of much of the structure and process of tort law.

25/ The duty to warn has been a particularly fertile ground for such after-the-fact compensation oriented findings of fault. It is all too easy after the occurrence of an injury to postulate a warning that might have influenced the plaintiff to be more careful or to reconsider his action, no matter how fanciful or unreasonable such a warning might appear prior to the injury. Such analyses have been a major factor in the medical malpractice and product liability litigation explosion.

26/ A recent and almost classic example of such compensation oriented liability findings is the California Supreme Court's decision in Bigbee v. Pacific Tel. & Tel. Co., 34 Cal.3d 49, 665 P.2d 947 (1983). In that case, a man was injured when an allegedly intoxicated driver lost control of her car, veered off the street into a parking lot, and crashed into a telephone booth in which the man was standing. Suit was brought against the companies responsible for the design, location, installation, and maintenance of the booth. The Court, in an opinion authored by Chief Justice Rose Bird, found that the risk that someone might veer off the road and crash into the phone booth was not unforeseeable as a matter of law. The Court also determined that it was of no consequence that the harm to plaintiff came about through the negligent or reckless acts of an allegedly intoxicated driver. In a concluding footnote, Chief Justice Bird stated that "there are no policy considerations which weigh against imposition of liability" against the defendants even though their "conduct may have been without 'moral blame,'" and referred specifically to "the probable availability of insurance for these types of accidents . . . ." 665 P.2d at 953 n. 14.

If fault were no longer a central element in determining liability, the current tort system would in many ways be wasteful, inefficient and unfair in the extreme. 27/

Tort law thus has gradually (with a marked acceleration in recent years) been moving in the direction of no-fault liability without an adequate acknowledgement of either the existence or the implications of this development. The result is an increasingly common and perverse combination of fault-based levels of compensation based on no-fault liability.

The Undermining of Causation

Tort law traditionally has sought to place liability only upon those actors whose wrongful conduct actually caused an injury. This principle is found in the concept of "proximate cause," which requires a reasonable relationship between a given cause and effect. For some time, however, proximate cause has been under systematic attack. No single doctrinal change can be identified as the primary vehicle for this attack. Rather, the challenge has come through a variety of questionable practices and doctrinal innovations.

One such development has been the increasing use of joint and several liability to shift the cost of compensation to "deep pockets." Joint and several liability developed in the context of defendants acting in concert. 28/ Over the years, however, it increasingly has been used to make a defendant with only a limited role in causing an injury bear the full cost of compensating plaintiff, even in some cases where the plaintiff may have been largely responsible for his own injury. 29/ The result has been that joint and several liability in the absence of concerted action can and does lead to highly inequitable

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27/ For example, the way in which damages are measured and awarded can only be justified, if at all, on the basis of redressing wrongful conduct. Once wrongdoing is removed as an element of liability, many of the principles involving damages become grossly unfair.

28/ See generally Prosser and Keeton on Torts (5th ed. 1984), Chapter 8. As may be obvious, as with so many other aspects of tort law, fault remains a central and essential justification for joint and several liability.

29/ The application of joint and several liability in cases where there in fact is no concerted action is discussed in some detail in Speiser, Krause & Gans, The American Law of Torts § 3:7 (1983). It is interesting to note that the English courts apparently have maintained the traditional common law basis for joint and several liability, and have refused to apply such liability in the absence of concerted action. Id.

treatment of defendants, particularly "deep pocket" defendants. 30/

A related development is the way in which joint and several liability has been applied by some courts to theories of "enterprise" or "market share" liability for injuries caused by generic products (e.g., DES). "Market share" liability, in its pure theoretical sense, allocates liability among manufacturers of a generic product on the basis of their share of the relevant market. While there can be some serious problems and inequities with this approach, as long as all relevant manufacturers (and their respective market shares) are accounted for, and the product is truly generic in nature, such an allocation of liability may be the only way plaintiffs in some cases can obtain compensation for injuries caused by wrongdoing on the part of the manufacturers of such a product. Serious problems with this approach arise, however, when not all relevant manufacturers are accounted for, or where the product is not truly generic in nature. Even more troublesome is the approach of several courts which use some industry liability allocation formula, but then apply joint and several liability to all defendants. See, e.g., Abel v. Eli Lilly & Co., 418 Mich. 311, 343 N.W.2d 164, cert. denied., 105 S.Ct. 123 (1984); Collins v. Eli Lilly Co., 116 Wis.2d 166, 342 N.W.2d 37 (1984). This, in fact, represents a clear abuse of joint and several liability, and cannot be justified on the basis of the unique difficulties plaintiffs sometimes face in identifying the manufacturer of an injury causing generic product.

A third means that has been used to undermine causation -- increasingly common in toxic torts cases -- is the use of presumptions or burden-shifting techniques to force the defendant to prove the lack of causation in order to avoid liability. 31/ Frequently, this amounts to asking the defendant

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30/ The legal doctrine of contribution in theory could serve to mitigate some of those inequities. In certain areas of the law, such as antitrust law, where joint and several liability generally tends to be applied to established businesses, contribution appears to function quite well. (And, in any event, joint and several liability in antitrust cases is virtually always based on concerted action -- the traditional basis for such liability.) In personal injury cases, however, many multi-defendant cases involve a "deep pocket" and one or more defendants who are either judgment proof or have limited assets or insurance coverage. In such cases, the belief that contribution serves as a mitigating factor is largely illusory.

31/ A particularly dramatic example of such a practice can be found in Allen v. United States, 588 F.Supp. 247 (D. Utah 1984), a low-level radiation exposure case in which the court shifted to the government the burden of proving that particular cancers were not caused by radiation exposure.

to meet an impossible burden of proving the negative.

Another way in which causation often is undermined -- also an increasingly serious problem in toxic tort cases -- is the reliance by judges and juries on noncredible scientific or medical testimony, studies or opinions. It has become all too common for "experts" or "studies" on the fringes of or even well beyond the outer parameters of mainstream scientific or medical views to be presented to juries as valid evidence from which conclusions may be drawn. The use of such invalid scientific evidence (commonly referred to as "junk science") has resulted in findings of causation which simply cannot be justified or understood from the standpoint of the current state of credible scientific and medical knowledge. 32/ Most importantly, this development has led to a deep and growing cynicism about the ability of tort law to deal with difficult scientific and medical concepts in a principled and rational way.

These are but four developing areas that are causing defendants to be found liable for injuries they did not cause. The one common attribute of these developments is that the defendants to whom liability is shifted almost invariably happen to be those with the deepest pockets.

The Explosive Growth in Damage Awards

Another area of great concern is the explosive growth in tort damages awards over the last decade. A few statistics will illustrate this point.

Jury Verdict Research, Inc., publishes data on the average jury verdict in product liability and medical malpractice cases. The service's latest report 33/ shows that the average medical

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32/ An instructive decision in this regard is the district court opinion in Johnston v. United States, 597 F.Supp. 374 (D. Kansas 1984). The court there exhaustively reviewed the theories and credentials of a number of plaintiffs' experts on the effects of low-level radiation, and rejected their testimony as biased, contradictory and totally without scientific merit. Of particular interest is the court's frustration that these same experts had played prominent roles in major radiation cases such as Silkwood and Allen, and that their testimony was being used in numerous cases throughout the country. The court noted its disappointment that such "so-called experts can take such license from the witness stand [to] say and conclude things which . . . they would not dare report in a peer-reviewed format." Id. at 415.

33/ Jury Verdict Research, Inc., Injury Valuation: Current Award Trends No. 304 (1986). The 1985 data provided by the service is incomplete, and is subject to refinement. The (CONTINUED) malpractice jury verdict increased from $220,018 in 1975 to $1,017,716 in 1985 (see Chart D), a 363% increase. 34/ Average product liability jury verdicts during this same period increased from $393,580 to $1,850,452, a 370% increase (see Chart E). 35/

Interestingly, much of this increase can be attributed to a remarkable growth in verdicts above $1 million. In 1975 there were three million-dollar medical malpractice verdicts and nine million-dollar product liability verdicts reported by Jury Verdict Research, Inc. In 1984, the numbers had grown to 71

33/ (FOOTNOTE CONTINUED)

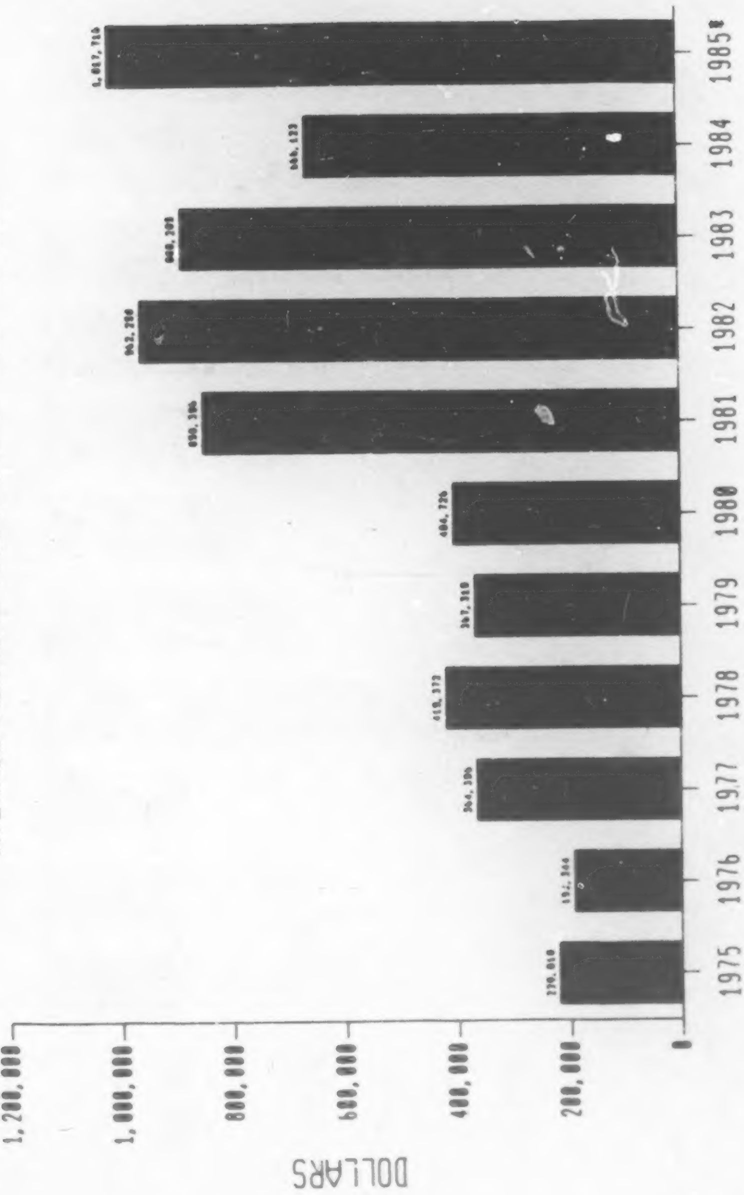
service indicates that it bases "its findings, values and probabilities upon collected verdicts using accepted statistical methods in their analysis and application." Nevertheless, the reported average annual verdicts are not used by the Working Group as an accurate statement (though they may very well be) of the average jury verdict in any particular year. Rather, the Working Group found the Jury Verdict Research data useful for purposes of showing the trend in jury verdicts over the last decade. In this regard, it should be noted that the service has used the same basic methodology since well before the relevant reported years. Moreover, while there are different estimates of average jury verdicts for particular areas and years, a number of other sources that have collected such data -- including the Institute for Civil Justice -- corroborate the overall trends reported by Jury Verdict Research, Inc.

34/ This percentage increase is consistent with a survey of California Superior Court medical malpractice verdicts. That survey shows the average medical malpractice award as increasing from $152,970 in 1975 to $649,210 in 1983, a 324% increase. American Medical Association Special Task Force on Professional Liability and Insurance, Professional Liability in the '80s (October 1984). Because the $250,000 cap in California on awards for non-economic damages in medical malpractice cases was only recently affirmed as constitutional (see Chapter 4), it is unclear what effect, if any, the cap has had on malpractice verdicts in California. It is worth noting, however, that the recent insurance problems for medical malpractice have been far less serious in California than in many other states, and that in California the insurance crisis primarily has affected areas other than medical malpractice (e.g., municipal liability).

35/ This remarkable increase is also reflected in the Institute for Civil Justice study of civil jury verdicts in Cook County, Illinois. For example, the average wrongful death award in Cook County increased (in constant dollar terms) from $166,000 in 1970-74 to $336,000 in 1975-79, a doubling over roughly half a decade. M. Peterson, Compensation of Injuries: Civil Jury Verdicts in Cook County 54 (1984).

CHART D

AVERAGE MEDICAL MALPRACTICE JURY VERDICT

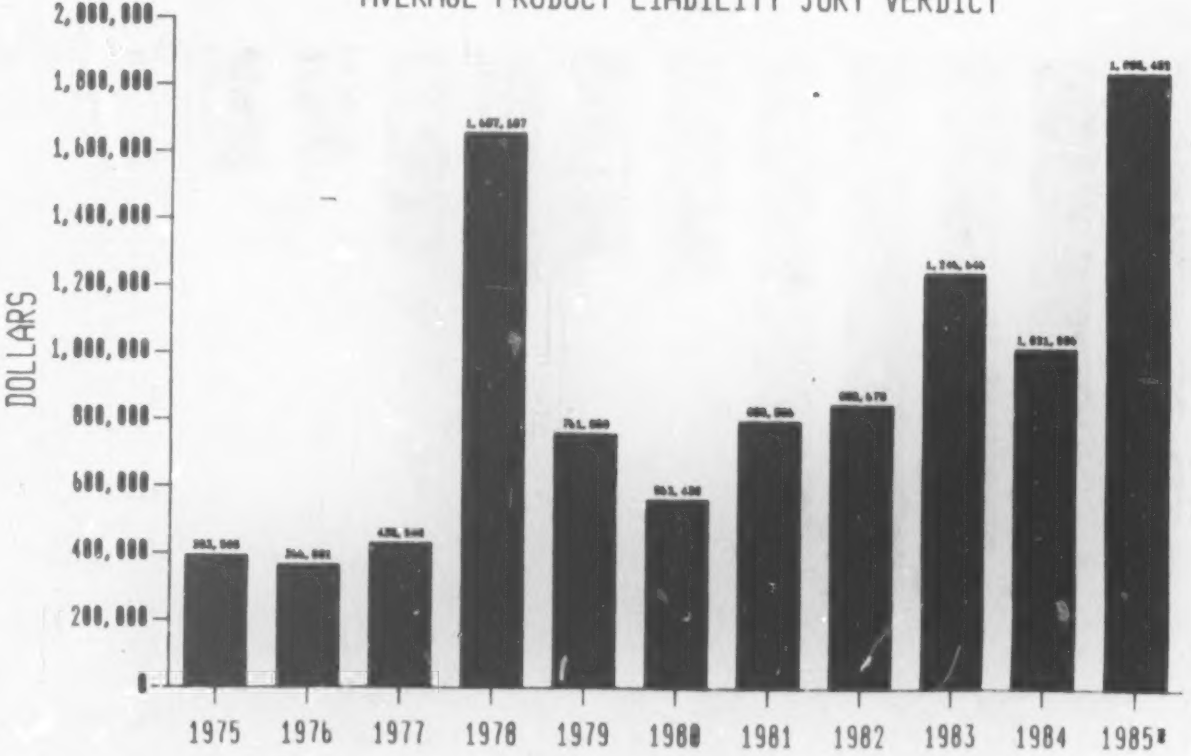


* 1985 Information Not Complete

Source: Jury Verdict Research, Inc.

CHART E

AVERAGE PRODUCT LIABILITY JURY VERDICT



Source: Jury Verdict Research, Inc.

* 1985 Information Not Complete

million-dollar medical malpractice verdicts and 86 million-dollar product liability verdicts (see Chart F), an increase of over 1200% in the number of such verdicts. 36/ If these million-dollar verdicts are deleted, the increase in average verdicts is reduced sharply. For example, the increase in the average medical malpractice jury verdict from 1975 to 1985 drops to 26% and the comparable average product liability verdict jury increase is 87%. 37/ This clearly suggests that the explosion in damages has come largely at the high end of the awards scale.

The Jury Verdict Research data is of only limited value on the absolute number of million-dollar payments, since in all likelihood the vast majority of such payments are through settlements rather than verdicts. The data is highly relevant, however, in that it shows that the percentage rate of increase of verdicts is far higher for large verdicts than for small or medium-size verdicts. Since a significant distinguishing factor between large verdicts and small or medium-size verdicts is that large verdicts tend to be composed to a far greater extent of non-economic damages, 38/ this strongly suggests that non-economic damages play a major role in the explosive growth in large verdicts (as compared to the much more moderate growth in small and medium-size verdicts).

While it is not possible to quantify precisely how much particular elements of damages have contributed to this explosion, it appears that non-economic damages are a substantial factor. Such damages include non-pecuniary compensatory damages for intangible injuries such as pain and suffering and mental anguish, as well as punitive damages. Such non-economic damages are inherently open-ended and subjective, and, therefore, easily susceptible to dramatic inflation. Of interest in this regard is a recent preliminary study by the Institute for Civil Justice which indicates that the average punitive damage award in Cook County, Illinois, increased from $63,000 in 1970-74 to $489,000 in 1980-84 (see Chart G). 39/ Of

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36/ Jury Verdict Research, Inc., supra. The trend toward million-dollar verdicts is also documented by the Institute for Civil Justice. M. Shanley & M. Peterson, Comparative Justice: Civil Jury Verdicts in San Francisco and Cook Counties, 1959-1980 26-30 (1983).

37/ Jury Verdict Research, Inc., supra.

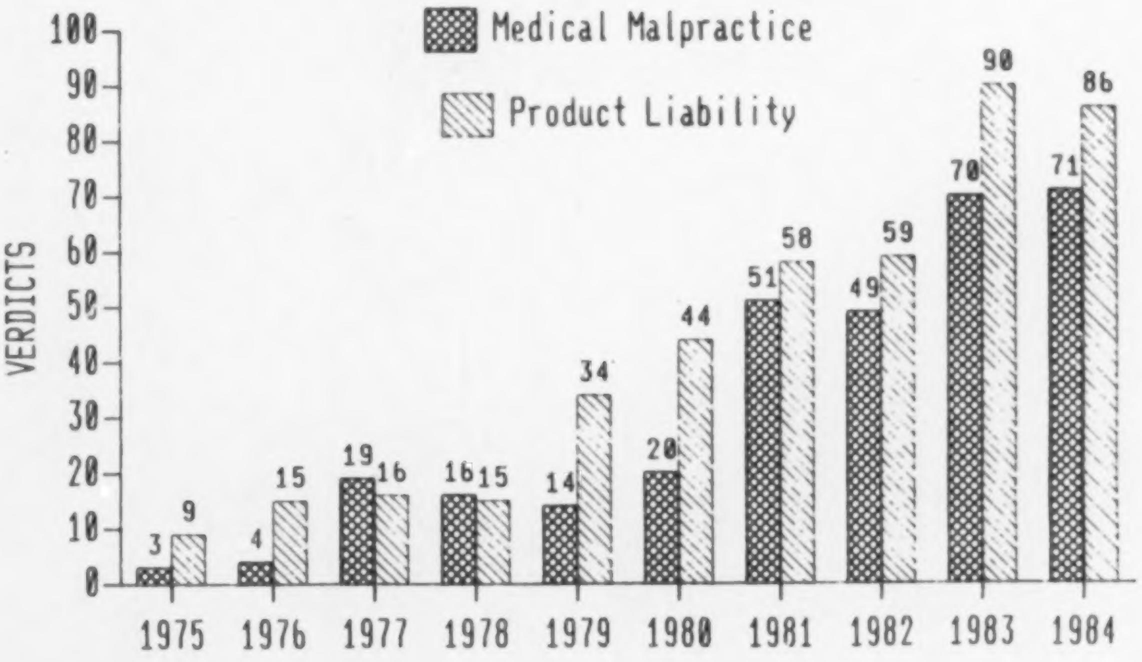
38/ H. Manne, Medical Malpractice Policy Guidebook 138-39 (1985). The study shows that for medical malpractice awards between $100,000 and $200,000, non-economic damages account for approximately 27% of the total award, while for awards above $600,000, the non-economic share increases to 54%.

39/ M. Peterson, Punitive Damages: Preliminary Empirical

(CONTINUED)

CHART F

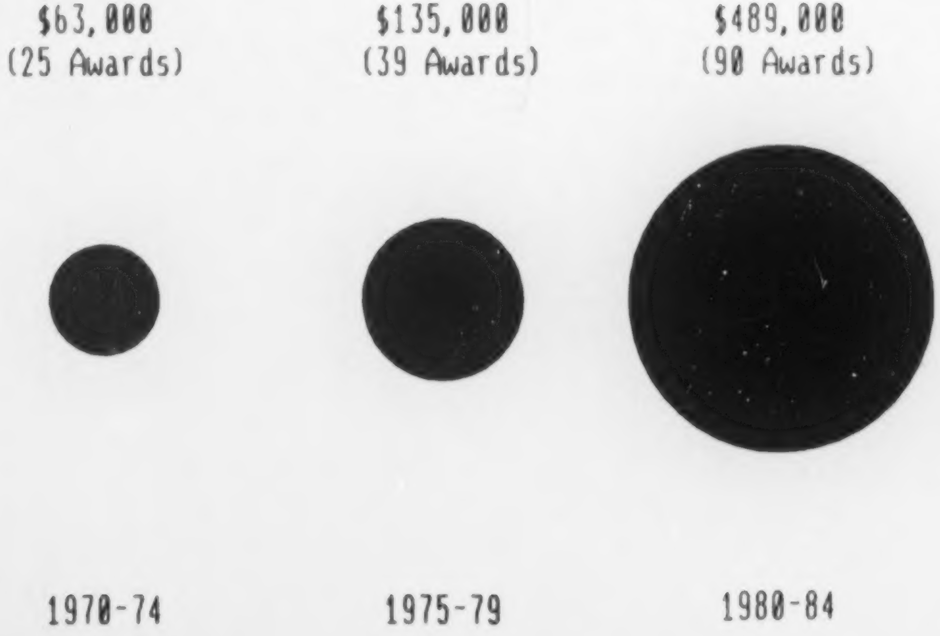
MILLION DOLLAR JURY VERDICTS



Source: Jury Verdict Research, Inc.

CHART G

AVERAGE PUNITIVE DAMAGE AWARD IN COOK COUNTY*



Source: Institute for Civil Justice

*1984 Dollars

particular interest is that the average Cook County punitive damage award in personal injury cases increased from $40,000 in 1970-74 to $1,152,174 in 1980-84 (see Chart H). 40/

This explosion in damage awards, particularly in the case of non-economic damages, is vastly in excess of the rate of inflation over the comparable period. 41/ For whatever reasons, tort damage awards have suddenly soared in the United States without any apparent justification.

Excessive Transaction Costs

Another serious problem of the tort system is its extraordinarily high transaction costs. A study by the Institute for Civil Justice of the asbestos litigations shows that out of every dollar paid out by the asbestos manufacturers and their insurers as a result of the asbestos litigation, 62 cents on the verage is lost attorneys' fees and litigation expenses (see Chart I). 42/ This does not include the transaction costs borne by the courts in adjudicating these claims.

It also is worthwhile viewing the transaction costs from the

39/ (FOOTNOTE CONTINUED)

Findings 13 (1985). These averages were adjusted for inflation and are stated in terms of the 1984 dollar. The study's analysis of punitive damage awards in San Francisco also showed an increase in such awards, though of lesser magnitude than in Cook County.

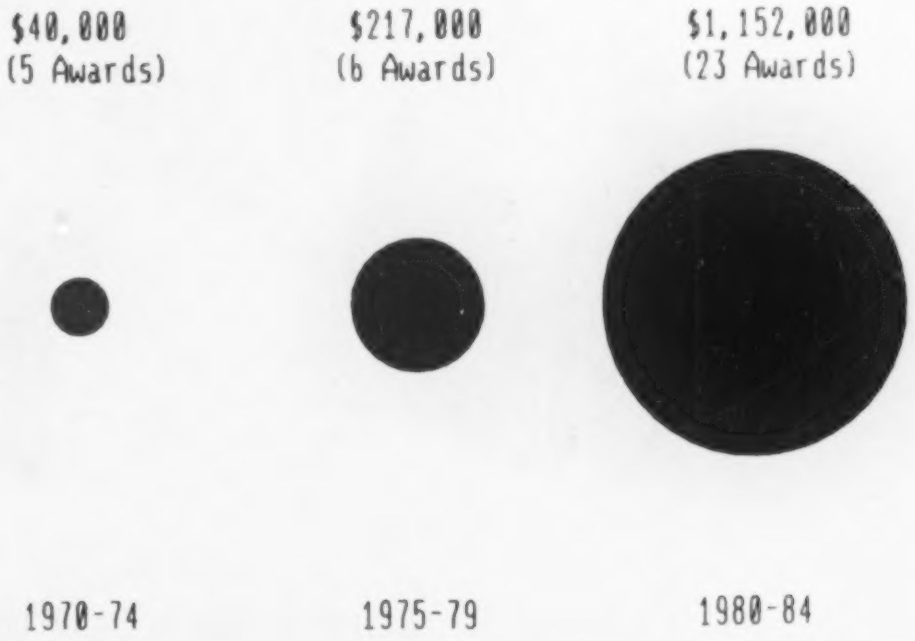
40/ Id., at 25 (also adjusted for inflation). Peterson notes that personal injury punitive damage awards in Cook County between 1980-84 amounted to over half of all punitive damages awarded in all case categories by Cook County juries from 1960-84.

41/ For purposes of comparison, one dollar in 1985 had approximately half the buying power of one dollar in 1975.

42/ J. Kakalik, P. Ebener, W. Felstiner, G. Haggstrom & M. Shanley, Variations in Asbestos Litigation Compensation and Expenses xviii (1984). These costs, of course, include both plaintiffs' and defendants' litigation expenses. In comparing the costs attributable to defendants' litigation expenses to the costs attributable to plaintiffs' litigation expenses it is useful to remember that defendants incur such costs whether or not they prevail, and, indeed, may incur substantial costs defeating even clearly frivolous claims. Measurements of plaintiffs' litigation expenses (such as in Chart I), reflect only those cases in which plaintiffs prevail, while defendants' litigation expenses include all cases, whether or not plaintiffs prevail.

CHART H

AVERAGE PERSONAL INJURY PUNITIVE DAMAGE AWARD IN COOK COUNTY*

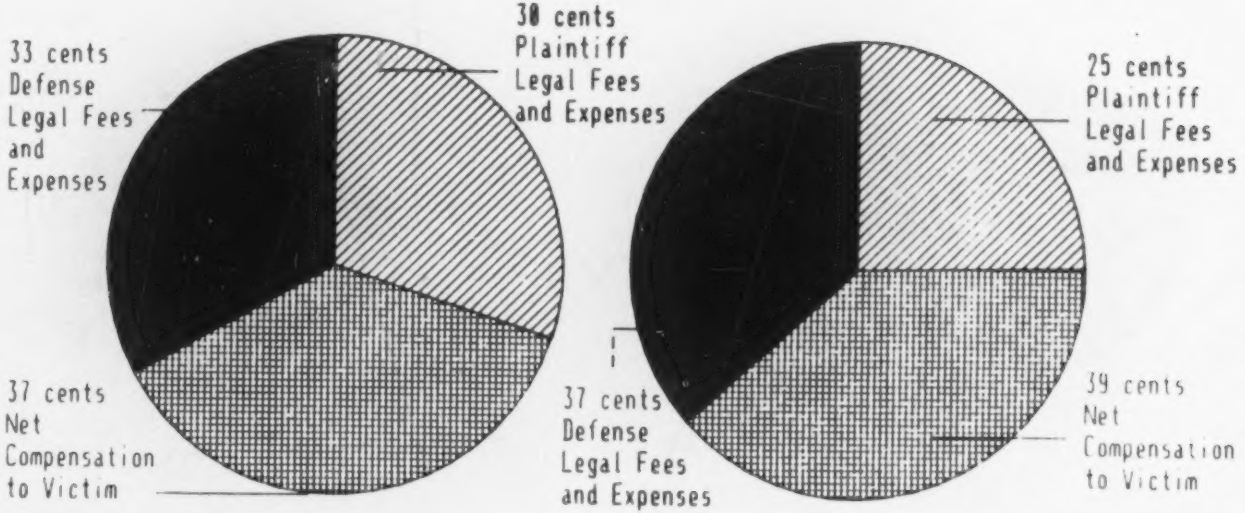


[illegible] Civil Just[illegible]

*1984 Dollars

CHART I

ALLOCATION OF EVERY DOLLAR PAID OUT IN ASBESTOS CLAIMS



Average Tried Claim

Average Closed Claim

Source: Institute for Civil Justice

perspective of the prevailing plaintiff. The study also shows that for every dollar awarded to plaintiff, 34 cents on the average is lost to legal fees and an additional 5 cents is lost to legal expenses. 43/ In some cases, legal fees alone amounted to as much as 45% of plaintiff's award. 44/

It is difficult to justify such extraordinary transaction costs. But it is particularly difficult to justify such costs when the costs often are borne largely by the seriously injured and by consumers who ultimately must pay for these costs through higher prices for goods and services. The only clear beneficiaries of this system appear to be lawyers.

II. BURGEONING TORT LIABILITY AS A MAJOR CAUSE OF THE INSURANCE AVAILABILITY/AFFORDABILITY CRISIS

The above discussion describes a tort system that in recent years has dramatically increased in scope. One way of measuring that increase is in terms of the increase in the number of tort lawsuits and in the level of damages awarded in such lawsuits. While the available data is limited, and by no means perfect, it clearly confirms that there has been a substantial increase in recent years in both the number of tort lawsuits and awarded damages.

The growth in the number of product liability suits has been astounding. For example, the number of product liability cases filed in federal district courts has increased from 1,579 in 1974 to 13,554 in 1985, a 758% increase (see Chart J). 45/ There is no reason to believe that the states courts have not witnessed a similar dramatic increase in the number of product liability claims.

A similar trend can be found in medical malpractice, where claims 46/ filed against physician-owned companies increased from 10,568 in 1979 to 23,545 in 1983, a 123% increase in four

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43/ Id., at 84. For tried claims, these costs increase to 39 cents and 6 cents respectively. Id.

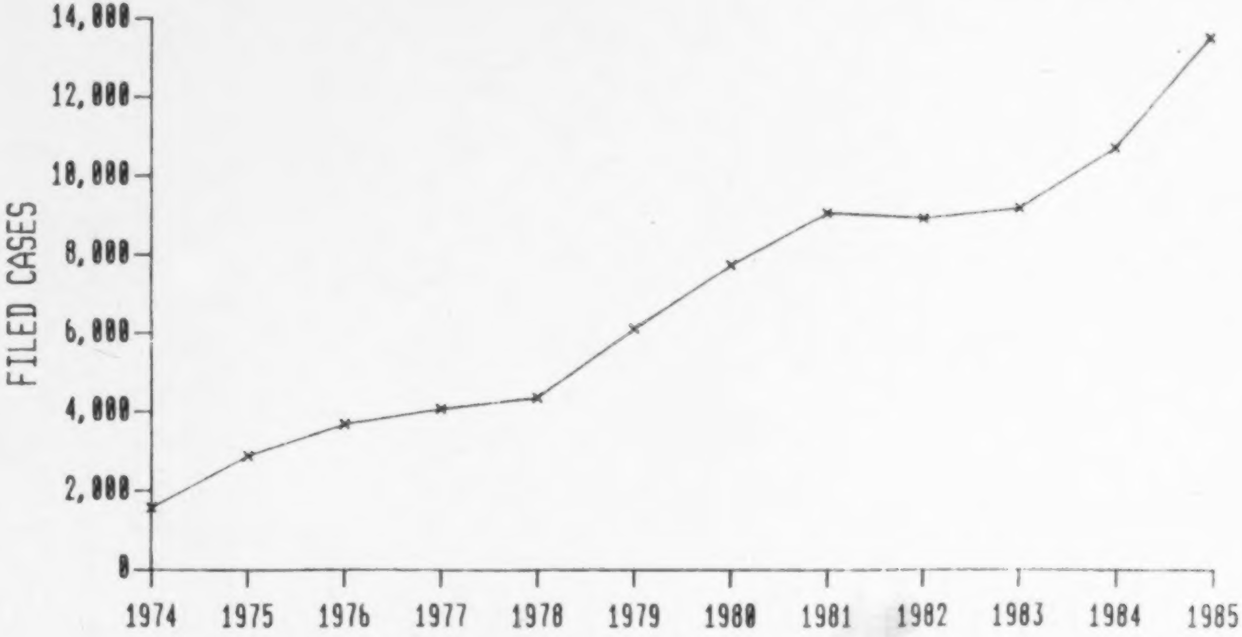
44/ Id. With legal expenses of 5%, prevailing plaintiffs in such cases receive only half of the awarded verdict.

45/ Administrative Office of the United States Courts.

46/ Claims do not, of course, translate directly into lawsuits, since most claims are resolved prior to the filing of litigation. But a substantial increase in claims almost certainly means a corresponding substantial increase in litigation.

CHART J

PRODUCT LIABILITY CASES FILED IN FEDERAL DISTRICT COURT



Source: Administrative Office of the United States Courts years. 47/ The number of medical malpractice lawsuits per 100 physicians more than doubled from 1976 to 1981, and for obstetricians/gynecologists actually tripled during this period. 48/ In federal courts, which contain only a fraction of all medical malpractice claims, such claims have increased almost three-fold in the last decade (see Chart K). 49/

A similar increase can be found in claims filed against municipal and county officials. A survey of over twelve hundred local governments found that such claims had increased by 141% between 1979 and 1983. 50/ Tort claims against municipalities also have increased dramatically in recent years. For example, New York City witnessed a 375% increase from 1977 to 1985 in personal injury claims, with a corresponding 345% increase in average settlement cost. 51/ The City's long-term liability for tort claims already filed is projected to be $1.5 billion. 52/

The explosive growth in damages over the past decade has already been related in detail. Suffice it to say that the increase in the average tort award appears to have outpaced even the extraordinary increase in the number of such lawsuits. The extent of some of these increases are difficult to comprehend. For example, one verdict reporting service found that the average jury verdict in personal injury lawsuits had increased by approximately 25% or more in three separate years (24.5% in 1980, 30.49% in 1981 and 27.54% in 1983). 53/ The average annual increase in such awards since 1975 has been over 15%. 54/ A subcategory of damages that dramatically illustrates this development is the average jury verdict for the wrongful death

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47/ American Medical Association Special Task Force on Professional Liability and Insurance, Professional Liability in the '80s 6 (November 1984).

48/ H. Manne, Medical Malpractice Policy Guidebook 18 (1985)

49/ Administrative Office of the United States Courts.

50/ Wyatt Co., Public Officials Liability Insurance: Understanding the Market (1986), page 22 (the provided 1984 data is incomplete, see pages 9-10, and therefore is not used for comparison).

51/ Statement by Mayor Edward I. Koch before the Governor's Advisory Commission on Liability Insurance, Feburary 21, 1986

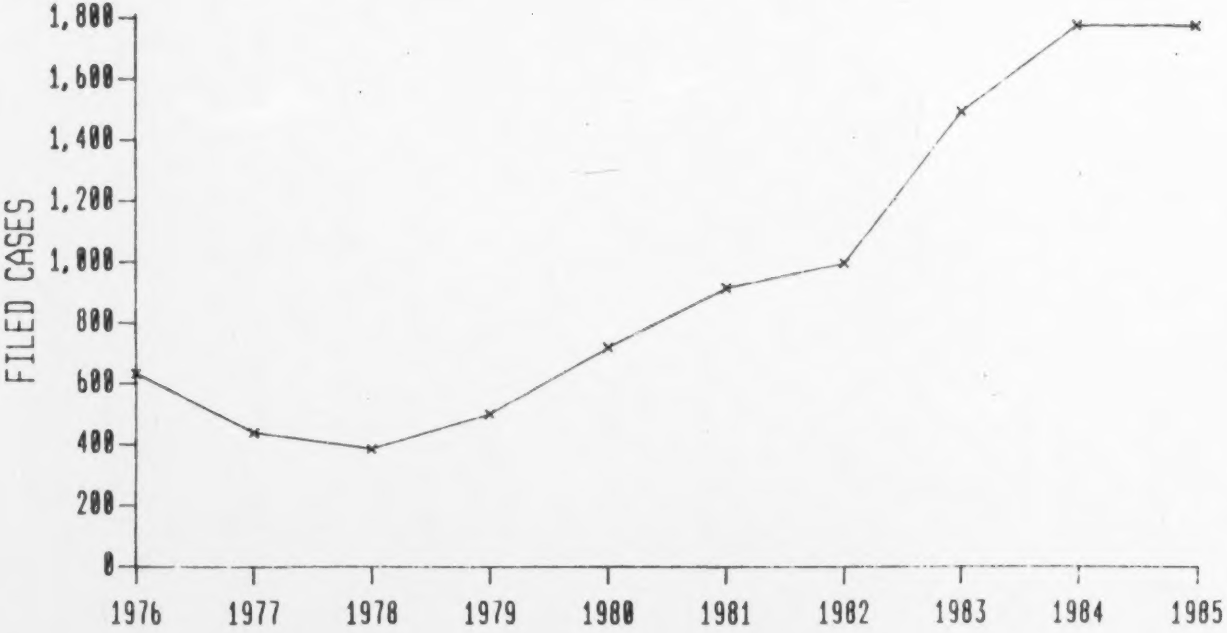
52/ Id.

53/ Jury Verdict Research, Inc., supra.

54/ Id. This is more than double the average annual CPI increase during the same period. Id.

CHART K

MEDICAL MALPRACTICE CASES FILED IN FEDERAL DISTRICT COURT



Source: Administrative Office of the United States Courts of an adult male. The average award increased from $223,259 in 1975 to $946,140 in 1985, a more than four-fold (324%) increase in ten years (see Chart L). 55/

The increase in the number of tort lawsuits and the level of awarded damages 56/ (or settlements) in and of itself has an obvious inflating effect on insurance premiums. To illustrate, assuming all other factors are held constant, 57/ if the number of lawsuits against a company or person doubles in ten years, and if the average damage award (or settlement) doubles over this same period, that company or person will experience at least a four-fold increase in insurance premiums over those ten years. As noted above, however, for both medical malpractice and product liability the last ten years have witnessed much more than a doubling in lawsuits and average awards.

The above observation leads to an important but troubling insight into the current insurance availability/affordability crisis. Some have speculated that the crisis is the result of the attempt by the insurance industry to recoup losses resulting from its underpricing in the late 1970's and early 1980's. If this theory is correct, then it would seem likely that as such losses are recouped, premiums would decline. The above analysis, however, suggests that while the insurance industry may have underpriced its product for a period of time, the current explosion in premiums results in large part from the fact that now that the insurance industry is facing substantial underwriting losses, it must price coverage to reflect the actual risks presented by tort law. In other words, for a variety of reasons, the insurance industry appears to have kept prices constant or engaged in price reductions in a period during which the risks generated by tort liability increased

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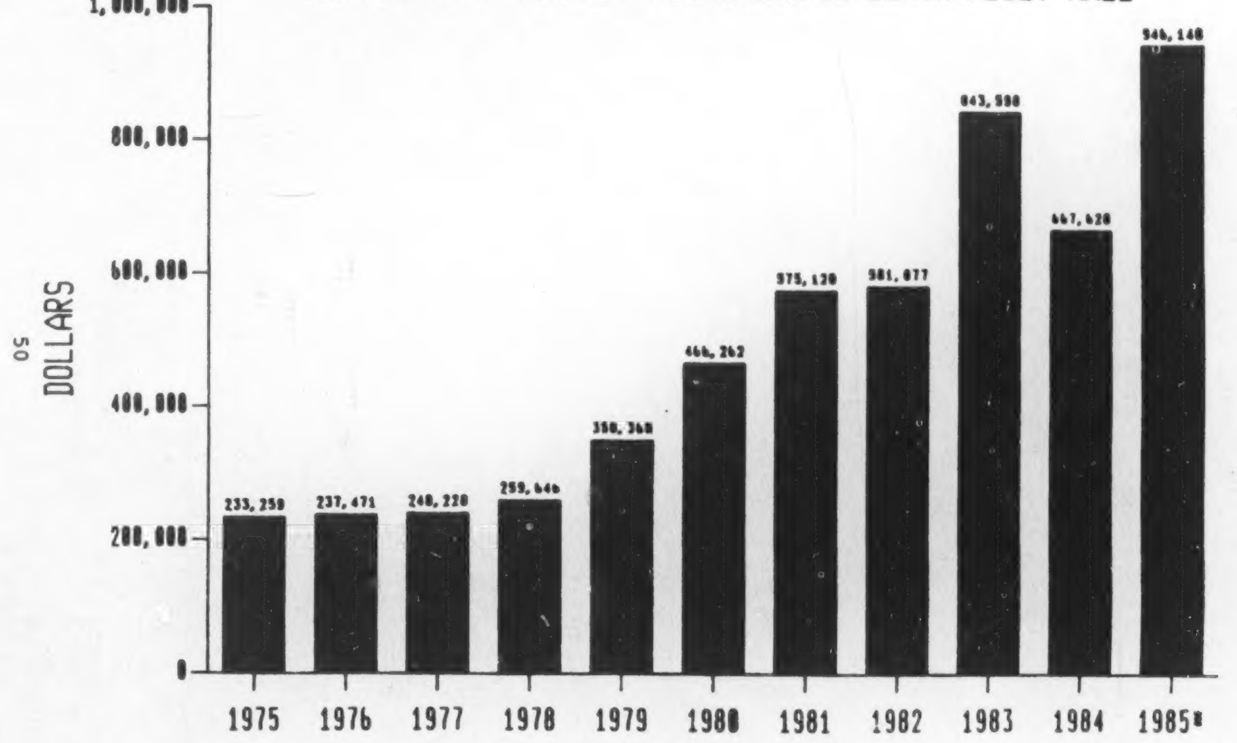
55/ Id.

56/ Jury verdicts, of course, represent only the tip of the claims resolution process. Most claims are resolved before trial. However, settlements by their very nature reflect the range of verdicts available to the plaintiff. Thus, as jury verdicts skyrocket, so do settlements. Settlements also reflect the plaintiff's likelihood of success. As tort law becomes more and more favorable to plaintiffs -- particularly in reducing or even eliminating plaintiff's burden of showing fault or causation -- settlements further increase. Accordingly, in addition to the obvious effect on settlements of increasing jury verdicts, liberalized standards of fault and causation increase the percentage of claims resolved favorably to plaintiff and increase the size of settlements.

57/ Of course, all factors are not held constant. For example, if there is an increase in the percentage of claims resolved favorably to plaintiffs, premiums would have to be increased correspondingly.

CHART L

AVERAGE JURY VERDICT FOR WRONGFUL DEATH ADULT MALE



Source: Jury Verdict Research, Inc.

* 1985 Information Not Complete

dramatically. Now that the industry is attempting to match premiums to risk, there appears to be a dramatic, pent-up increase in premiums to bring premiums back into line with rapidly growing liability risks.

The above analysis, if correct, is troubling in that it suggests that even after the insurance industry's underwriting profitability is restored, premiums are likely to remain relatively high. That is, while the more extreme availability problems may be resolved once the industry controls its underwriting losses, affordability problems may remain as a long-term fixture absent significant reforms of tort law.

There is, however, another important contribution of recent developments in tort law to the availability/affordability crisis which goes beyond the number of lawsuits and size of damage awards. The changing standards of liability and causation have generated tremendous uncertainty. The "rules of the game" of tort liability have changed so dramatically and rapidly in recent years that few are willing to speculate on what those rules will be even a few years hence. Invariably, however, those rules seem to have been changed to the prejudice of parties with pockets sufficiently deep to bear increasingly generous awards of compensation.

This uncertainty as to what the rules of tort liability applicable to any particular company, person or activity will be in future years makes it extremely difficult for the insurance industry to assess risk (and establish appropriate premiums) with any degree of confidence. This undoubtedly exacerbates the affordability problem, and may be a major factor underlying the availability problem. Simply put, insurance, like other business activities, operates most efficiently within a stable legal regime. Tort law, unfortunately, over recent years has been anything but stable.

The recent explosion in tort liability and the lack of legal certainty is a particularly noxious combination that seems to react almost synergistically in promoting the insurance availability/affordability crisis. The rapidly accelerating growth in both the number of tort lawsuits and the size of damage awards in and of itself significantly increases future liability risks. But that risk is magnified by the perception -- based in large part on the lack of a stable legal regime -- that this accelerating growth will continue unabated. The insurance industry thus appears to be extrapolating the massive liability surge of recent years into the future, and seems to be setting its rates in part on the assumption that the on-going deterioration of tort law will continue for some time. Simply put, assessments of future liability risks reflect not only the recent rapid growth in such risks, but the perceived likelihood that past excesses will be outpaced by the excesses yet to come. 58/

In conclusion, the current problems of tort law can be summarized as follows:

- Too many defendants are found liable (or forced into settlements) where there should be no liability, either because they engaged in no wrongful activity, or because they did not cause the underlying injury.
- Damages have become excessive, particularly in the area of non-economic damages such as pain and suffering, mental anguish and punitive damages. And,
- Transaction costs are far too high.

The ways in which these aspects of the tort system are contributing to the current insurance availability/affordability crisis can be summarized as follows:

- The private sector is being asked to carry a compensation burden which in some instances it simply cannot afford to carry without substantial economic dislocations. Thus, even where insurance is available, in order to carry this compensation burden, it often is priced at unacceptable levels.
- The affordability/availability problem is greatly exacerbated by the lack of a stable legal regime which would allow the insurance industry to assess liability risks with some degree of confidence.

58/ A recent Administration study of the childhood vaccine industry, for example, found that uncertainty as to tort liability was a major factor underlying the severe insurance availability problems facing the industry and jeopardizing the childhood vaccination program. See the Report of the Working Group on Vaccine Supply and Liability (April, 1985).

CHAPTER 3

RECENT INSURANCE INDUSTRY DEVELOPMENTS

The insurance availability/affordability crisis has led both the insurance industry and its customers to consider various changes to the ways in which liability risks are insured. The following is a description of the most significant of these developments and their immediate implications.

I. COVERAGE CHANGES

One of the most important of these changes has been the development of new commercial policy forms by the Insurance Services Office ("ISO"), the statistical and rate-making organization for the property-casualty industry. While these new forms have been filed with each state insurance department, most states have not yet acted on the new submissions.

These new policy forms are more limited in scope than the old forms in that they are written on a claims-made basis and permit certain coverages to be excluded entirely.

Claims-Made Policies

General liability insurance, including product liability coverage, traditionally has been written on an occurrence basis; that is, the policy applies to all injuries and damages that occur during the policy period irrespective of when claims are presented. Under claims-made coverage, the policy covers injuries and damages which occur during the policy period and for which claims are filed during the policy period.

The ISO submission provides that a policyholder can purchase unlimited tail coverage (the period during which claims are covered after termination of the policy) for a cost of up to 200% of the original premium. In addition, a five year extended claims reporting period for known claims is provided for situations where no other insurance is applicable. There is still disagreement over the reinstatement of aggregate policy limits for tail coverage and the effect of defense cost inclusions.

A claims-made policy covers claims occurring after the "retroactive date," ordinarily, the inception date of the policy. Under some circumstances, insurers will be permitted to advance the retroactive date, necessitating the purchase of tail coverage for incidents occurring during the prior period. The retroactive date may be advanced when: (1) there is a change of insurer, (2) there is a change in the insured's operation, (3) if the insured fails to inform the insurer of risks he knew or should have known about, or (4) with the consent of the insured.

The ISO has indicated that it does not intend to limit the use of claims-made policies to specific problem areas such as long-tail or latent injury exposures.

The claims-made forms have not yet been approved by the states, and twelve states have expressly disapproved them as filed. The ISO is working with the Insurance Commissioners to resolve differences.

The insurance industry has indicated that it wishes to use claims-made policies. In general, 1986 is viewed as a transition year during which insurers will train their personnel in the use of the new policy forms and adapt their computers to accommodate the changes. Insurers have indicated that in states where the new forms are not insured, they may use non-admitted subsidiaries or surplus lines carriers to provide the coverage to their clients on claims-made basis for large complex risks and risks in "volatile" classes, or else simply not provide coverage to those risks.

Claims-made policies and other limited coverages also are being adopted by reinsurers. Lloyd's of London has introduced a new claims-made form, as have Weavers and Trenwick American Reinsurance. Each policy is somewhat different. Trenwick, a United States reinsurance company, has stated that it will not write any general liability reinsurance on an occurrence basis after January 1 of this year. Trenwick also has written a claims-made form for use by its ceding companies for "difficult" risks. Other reinsurers have indicated they would reinsure both occurrence and claims-made policies, but would strongly encourage the use of claims-made for heavy casualty risks. As indicated in Chapter 1, some businesses already have been asked to take claims-made coverage for their excess limits coverage. Because of the many different claims-made forms currently being used, this is likely to cause gaps in coverage.

Laser Endorsements

The ISO policy form also includes "laser endorsements" which can be used to limit coverage. These provisions permit an insurer to exclude claims from a specific incident, product or period of time. Several Insurance Commissioners have objected to this provision and stated that, at a minimum, it should be revised to require the signature of the insured indicating an awareness of the exclusion. The inclusion of a laser endorsement would necessitate either the insured's purchase of tail coverage for that product or incident, or the insured's "going bare" for that liability.

Pollution Exclusion

Both the new ISO and Lloyd's of London claims-made commercial general liability policies specifically exclude pollution coverage. Traditionally, the general liability policy has included the business community's liability for damage caused by the "sudden and accidental" discharge of toxic substances. Environmental Impairment Liability ("EIL") policies are used to cover damages from gradual pollution incidents. In a number of highly controversial cases, courts have expanded the meaning of "sudden and accidental," causing insurers to be liable for EIL-type (gradual pollution) coverage when it was not intended under the policy.

As a result, insurers currently are reluctant to provide any pollution coverage, though Lloyd's of London has indicated a willingness to cover some liability at additional cost on a "named peril" basis only.

Defense Cost Inclusion

Ordinarily, the costs of defending against liability claims are not included within the aggregate limits of the commercial general liability policy. Insurers traditionally have controlled the defense of claims against their insureds by engaging defense counsel and by governing the vigor with which a claim is challenged. The insurers paid all costs, and the full amount of the policy limits were available to pay any settlement or judgment against the insured.

During the product liability crisis of the mid-1970's there were a number of allegations that insurers were, in fact, fueling the claims situation by settling too quickly in many cases that the insureds believed should have been more vigorously contested. As a result, many companies insisted that their insurance contracts include a right to at least partial, if not full, control of defense strategy.

In the mid-1980's, defense costs have escalated rapidly, mostly because of the cost of attorneys' fees, and possibly, in part because of the insureds' desires to contest claims to the fullest degree possible.

In order to control costs, the ISO had proposed to change the commercial general liability form to include defense costs within the aggregate limits of the policy. This practice already is incorporated in at least some other policy forms. 1/

1/ Business Insurance, December 9, 1985, page 1.

The proposal brought a sharp response from insureds, the bar, and the Risk and Insurance Management Society, a trade association of risk managers and insurance buyers. They believe that there will be cases of defense costs exceeding the limits, leaving no money to pay a settlement or judgment. Some are concerned that defense counsel may urge settlement of unworthy claims in order to prevent defense costs from exhausting all available coverage. Others believe that there will be a spate of bad faith claims against insurers when the policy limit is used for legal costs and the insured is left liable for damages.

In response to the concerns of insurance customers, regulators and brokers, the ISO has revised its proposal so that up to 50% of the aggregate limits may be spent on defense costs before the policy limits will begin to be reduced by those expenses. An endorsement will be available so that up to 300% of the limit may be spent on defense costs before the policy limit is affected. A discount will be applied if the policyholder buys less than the 300% endorsement. Insurers apparently will have the option to apply an endorsement which will charge all defense costs to the policy limits. 2/

At its annual meeting in December, the National Association of Insurance Commissioners passed a resolution urging states not to approve the ISO proposal until the proposal can be studied by the Commissioners. The ISO, which had hoped to initiate the defense cost change in July of 1986, will postpone filing its request with the states until at least February 15, 1986. 3/

II. ALTERNATIVE INSURANCE MECHANISMS

As liability insurance becomes unavailable or unaffordable, means of liability protection outside the conventional insurance markets increasingly are being sought and used.

2/ Business Insurance, December 16, 1985, page 1.

3/ Business Insurance, December 23, 1985, page 1.

Insurance Company Creation (Captive or Other)

One response available to large companies unable to buy the insurance coverage they need is to set up their own insurance company. Thirty-three major United States companies recently have established an offshore insurer, A.C.E. Insurance Company, which began operation in November, 1985, and provides up to $150 million in liability coverage. Founding companies include IBM, GE, U.S. Steel and Chase Manhattan, as well as other companies. While A.C.E. offers coverages not available elsewhere, its policies are available only to large companies since it only pays claims exceeding $100 million.

In addition, it recently was announced that a group of fifteen chemical and petrochemical companies are creating a company called CASEX, which would provide excess limits coverage for products, directors and officers, and sudden and accidental pollution liability.

Another group of fifty United States banks are creating a mutual insurer, Bankers' Insurance Co., Ltd., to provide directors and officers liability coverage and bankers blanket bonds.

During the medical malpractice crisis in the early to mid-1970's, groups of medical professionals unable to obtain malpractice coverage formed their own companies, commonly known as bedpan mutuals, to handle their claims. Such insurance groups currently provide about half of the coverage in the malpractice liability market.

Self-Insurance

Some industry groups and trade associations, as well as municipalities in several states, have joined together to self-insure as groups, and others have been able to set up a formal self-insurance program just to handle their own claims. 4/

Self-insurance, either individual or group, also has been a useful vehicle for municipalities for which insurance has become either unavailable or unaffordable.

One major problem encountered by firms seeking to set up self-insurance programs is that reserves for self insurance are not

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4/ A formal self-insurance program is different from "going bare" in that the former sets up reserves to cover claims and treats it similar to an insurance system whereas the latter simply hopes claims do not occur, which may cause financial difficulties if and when they do occur.

accorded the same tax treatment as insurance company reserves, in that self-insurance reserves are fully taxable. While this presents no problem for municipalities and other tax-exempt entities, it is a major hurdle for private entities.

Small firms are generally unable to establish a meaningful self-insurance program individually, but may benefit from group self-insurance if no other insurance is available.

Product Liability Risk Retention Act Groups

The Risk Retention Act ("RRA"), 15 U.S.C. § 3901 et seq., was intended as a mechanism to (1) create an alternative product liability insurance market, and (2) provide a means for smaller insurance buyers to purchase general liability insurance -- including product liability coverage -- as groups. The RRA evolved from an intensive interagency study of the product liability "crisis" in the mid-1970's. President Reagan signed the Act in September 1981, noting that it was a "marketplace solution" to provide product manufacturers, distributors and sellers with affordable product liability insurance.

A Risk Retention Group ("RRG") is formed by any number of product sellers as an insurance company licensed to operate under the laws of any state. The RRG may provide only product liability and completed operations coverage to its members. (Completed operations is work performed by a contractor or product manufacturer installing its product.) The RRG may sell insurance in any state without meeting the licensing or other regulatory requirements of any state other than its domicile. No state may discriminate against an RRG, but states may impose normal premium taxes and enforce compliance with unfair claims settlement practices statutes.

The Act is restrictive in that it limits a RRG to products and completed operations coverage, but permits the establishment of a domestic group captive that is able to do business countrywide.

A Purchasing Group ("PG") may be formed to negotiate for a group policy from any insurer to cover product liability completed operations, and commercial general liability when either of the first two coverages are included. The PG and any entity providing services to the PG are exempt from any state law which would prohibit the PG from purchasing this coverage on a group basis.

A group of companies purchasing together presents an attractive premium base with lower administrative costs to the insurer. In a tight market small companies are subject to cancellation or sharply higher prices because an insurer may prefer to use its resources on a few large risks. The provisions for purchasing groups was necessary to overcome statutes and regulations in about forty-four states which prohibited so called "fictitious groups" set up for the purpose of buying property or casualty insurance on a group basis.

Very few companies have used the RRA to date, but the rapid change in market conditions likely will lead to a much greater interest in its provision.

One reason that the RRA has been little used is the fact that it is limited to products and completed operations coverages, although groups may include other coverages as long as products is the primary purpose. It is a useful means of expanding insurance capacity, and would provide additional capacity in the alternative market if the products limitation were removed.

III. STATE REGULATORY DEVELOPMENTS

State legislators and insurance regulators have recognized the severity of the liability insurance crisis, and have responded in a variety of ways. One state has barred cancellation or non-renewal of policies and prohibited any increases in the cost of policies in effect. Several other states are considering similar actions. The National Association of Insurance Commissioners adopted a resolution opposing mid-term cancellations and short notices of non-renewal. Other states are implementing or considering the use of Market Assistance Programs, which are voluntary assigned risk pools designed to take risks such as day care centers on a rotating or shared basis. Yet other states are considering joint underwriting associations in which the state regulator mandates the sharing of certain risks

Half the states have "file and use" rate regulation in which the insurance department is notified of a rate increase which becomes effective without action by the regulator. Many of these states reportedly are rethinking their systems because of the sharp increases in the rates of some of the problem lines of coverage.

Regulators normally have viewed commercial insurance as transactions between knowledgeable buyers and sellers, and, accordingly, have refrained from interfering with the market's operation. The recent concerns expressed by the Insurance Commissioners is a measure of the depth of the availability/affordability crisis, and may foreshadow a heightening in the regulatory "oversight" of commercial insurance.

CHAPTER 4

TORT LAW REFORM

As discussed in Chapter 2, two primary areas have been the focus of the Working Group's examination into the crisis in liability insurance availability and affordability: the current economic difficulties of the insurance industry; and, the extraordinary growth in tort liability in recent years. For the reasons discussed in Chapter 2, while it seems likely that the insurance industry will be able to work its way out of its present economic straits, it is very unclear -- if not doubtful -- that this will significantly alleviate the crisis in insurance availability and affordability. Early indications are that insurers will continue to avoid areas that present a high risk of tort liability, or, where they do provide insurance, will demand high premiums. That is, while the more extreme aspects of the availability crisis may be resolved once the industry regains its desired level of profitability, it appears unlikely at this time that the high premiums that have led to serious affordability concerns will be reduced significantly.

For these reasons, as well as for the other reasons discussed in Chapter 2, there appears to be little that can or should be done by the federal or any other government to "remedy" the economic factors that underlie the current availability/affordability crisis. The excesses of the tort system, however, present a very real opportunity to address a major cause of the insurance crisis with sensible and appropriate reforms. And while some of the changes in the insurance market currently under contemplation (see Chapter 3) probably will relieve some availability/affordability problems, it seems unlikely that these changes will provide long-term, systemic relief without fundamental reforms of tort law.

The following is a list of eight tort reforms that would bring a greater degree of rationality and predictability to tort law, and thereby significantly assist in resolving the availability/affordability crisis. This is by no means an exhaustive list of possible tort reforms. Nor does the accompanying discussion of these reforms indicate how they necessarily should be implemented; that is, on the federal or state level, or through legislative or judicial modification of the law. Rather, this list identifies eight recommended tort reforms which if implemented should return tort law to a credible fault-based compensation system that provides a fair and reasonable level of compensation to deserving plaintiffs through a more predictable and affordable liability allocating mechanism. While these reforms undoubtedly will be resisted by some, they in fact are quite modest and should not dramatically alter the basic principles of tort law as those have existed for centuries.

Recommendation No. 1: Retain fault as the basis for liability.

For the reasons discussed in Chapter 2, fault should be retained as a basis for tort liability. As noted there, fault is the only mechanism in tort law for distinguishing desirable from undesirable conduct, and is an indispensable predicate to many other aspects of the tort liability system without which the system would generate arbitrary and unfair results.

For non-product liability cases, negligence should remain the applicable standard of liability. Strict product liability should under no circumstances be extended outside the traditional area of product injuries. Thus, theories which would apply strict product liability to landlords or to professionals providing services (e.g., pharmacists, architects, etc.) should be strongly resisted and expressly rejected. The trend in some states 1/ to extend strict liability doctrines outside the area of product injuries is a highly pernicious development which will significantly undermine the ability of those sectors of our economy to function properly.

Strict product liability in its traditional sense represents a sensible application of fault-based liability to the realities of modern industrial life. The Working Group, accordingly, does not recommend the abolition of strict product liability, provided the doctrine is kept within its traditional bounds. Unfortunately, strict product liability has been subject to extensive abuse that often has had the effect of transforming the doctrine in practice into absolute liability.

The following are the elements of a strict product liability standard which does not present an impossible or unfair burden to plaintiffs in demonstrating fault on the part of defendant-manufacturers, while at the same time not establishing a scheme of absolute liability which simply uses the manufacturer as an insurer for all risks of injury.

- Liability should be predicated on the existence of a defect which is found to make the product unreasonably dangerous.
- Defendants should only be held liable for uses of a product that are both reasonable and foreseeable. Liability should not be predicated upon unreasonable or unforeseeable alterations of a product that cause the injury, particularly where such alterations are prohibited or warned against. (Alterations, in this regard, can include the failure to provide required and reasonable safeguards, maintenance or inspections.)

1/ See in this regard the recent opinion of the California Supreme Court in Becker v. IRM Corp., 38 Cal.3d 454, 698 P.2d 116 (1985), extending strict product liability to landlords.

- Manufacturers should not be liable for defects which have been the subject of an adequate warning or which are readily apparent to the reasonable consumer. Manufacturers should only be required to warn with regard to uses of a product that are both reasonable and foreseeable.
- Manufacturers should only be held to the state of the art in existence at the time of manufacture of the product. Manufacturers should not be held liable for unknown or unknowable hazards.

The above elements, if applied in a principled manner, should ensure that strict product liability will serve to compensate persons injured as a result of a manufacturer's fault, while preventing that liability doctrine from simply being used as a risk spreading mechanism designed to operate as a product-based insurance scheme.

Recommendation No. 2: Base causation findings on credible scientific and medical evidence and opinions.

One of the most pernicious developments in tort law has been the extent to which causation findings are based on fringe scientific or medical opinions well outside the mainstream of accepted scientific or medical beliefs. Increasingly, juries are asked to make difficult decisions about highly complicated issues of science and medicine. Unfortunately, the personality and demeanor of expert witnesses often may be more critical in making such determinations than decades of evolving scientific and medical investigation and thought.

This problem has resulted in the growing perception that the tort system often is wholly arbitrary in allocating liability in cases involving difficult issues of science and medicine. This is a particularly problematic situation in toxic tort and drug liability cases. 2/

There are a variety of reasons for this problem:

- Many judges do not have the training or inclination to understand complicated scientific and medical concepts, and are unwilling or unable to devote the time and energy needed to educate themselves in a complex body of knowledge.
- In order not to deprive plaintiffs of their opportunity for compensation, many courts allow plaintiffs to take

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2/ For example, see the discussion of Johnson v. American Cyanamid Co., infra.

whatever scientific or medical views they may have -- however incredible -- to the jury.

- Many in the legal system do not appreciate how credible scientific and medical views develop, and the degree to which legal decisionmaking is a poor vehicle for developing such views

- There often is an understandable frustration with the fact that science and medicine frequently cannot offer the kind of certainty that the legal decisionmaking mechanisms strive to obtain.

The inability of the tort system to deal credibly with complicated scientific and medical issues strikes at the very heart of the ability of tort law to deal with the growing number of cases involving highly complicated scientific and medical issues. While there are no easy answers, there are several remedial actions that the Working Group recommends:

- Greater deference must be paid to government agencies and certain private institutions that have devoted decades of attention and millions of dollars to researching and trying to assess the value of medical and scientific developments. Where such agencies and institutions have determined that particular products, services or techniques are safe or socially beneficial, courts should tread very carefully in overruling those judgments through the vehicle of tort law. Lay juries are a very poor mechanism for second-guessing the judgment of established mainstream scientific and medical views. Other legal mechanisms for determining those views, such as rulemaking and licensing proceedings, generally are far superior in making credible determinations involving complicated issues of science and medicine.

- Courts must be more aggressive in determining the credibility of scientific and medical evidence and opinions before trial, and not simply allow parties to present any theory to the jury. Appellate courts, in turn, should give trial courts greater latitude in making such decisions in early stages of litigation. Judges, where feasible, should receive training on basic methods of scientific, medical and statistical analysis so that they can make such determinations. If necessary, impartial masters with appropriate training should be used for this purpose.

- Studies and opinions that have not been subjected to the peer review process should be presumed invalid. Where peer review has taken place, judges (or masters, where appropriate) should acquaint themselves with the results of such review.

- Courts must learn to accept the reality of uncertainty. They must understand that the fact that some degree of uncertainty always exists does not mean that every scientific or medical belief is as credible as the next. Judges and legislators must not try to "force" scientific certainty where such certainty simply is not possible. Attempts to do so through burden-shifting, presumptions or by requiring agencies to issue scientific "findings," simply create a misleading and deceptive gloss of scientific certainty that in fact does not exist. 3/ Ultimately, the legal system must accept the fact that some things are unknown, and, given existing methods and data, perhaps unknowable for the foreseeable future.

Recommendation No. 3: Eliminate joint and several liability.

One of the most troubling problems in tort law arises from injuries caused by multiple tortfeasors. Historically, such cases were handled by bringing separate actions against each defendant; joint and several liability only existed where concert-of-action was shown (see discussion in Chapter 2). Further, under the doctrine of contributory negligence, a negligent plaintiff could not recover damages from any defendant. Such an approach seemed harsh where plaintiffs were only minimally at fault for their own injuries. Eventually, and in part to remedy the harshness of the old rule, the doctrines of comparative fault and joint and several liability were developed to make it easier for plaintiffs to obtain compensation.

Comparative fault operates to assure that each party, including the plaintiff, is liable for its own fault. Joint and several liability, although originally applied to situations where concert-of-action was shown, is now in many cases applied to all defendants, regardless of their connection to the injury. Comparative fault, when coupled with the doctrine of joint and several liability, allows plaintiffs to recover the entire judgment from "deep pocket" defendants -- even if such defendants are only found to be minimally at fault. Joint and several liability thus frequently operates in a highly inequitable manner -- sometimes making defendants with only a small or even de minimis percentage of fault liable for 100% of plaintiff's damage. Accordingly, joint and several liability in the absence of concerted action has led to the inclusion of many "deep pocket" defendants such as governments, larger corporations, and insured entities whose involvement is only tangential and who probably would not be joined except for the existence of joint and several liability.

3/ As noted, the Working Group does not believe that scientific uncertainty can be handled simply by requiring government agencies to issue pronouncements of risk or causation for which there in fact is no credible basis.

Another problem area is the relationship of joint and several liability to "enterprise" or "market share" liability. See Sindell v. Abbott Laboratories, 26 Cal.3d 588, 607 P.2d 924, cert. denied, 449 U.S. 912 (1980). In theory, "market share" liability such as that established in the California Supreme Court's seminal opinion in Sindell attempts to allocate liability for a generic product (e.g., DES) among various producers on the basis of their share of the relevant market. Even assuming such an allocation is reasonable, 4/ some jurisdictions have devised variations of or alternative approaches to Sindell which apply joint and several liability among the producers of a generic product. 5/ See, e.g., Abel v. Eli Lilly & Co., 418 Mich. 311, 343 N.W.2d 164, cert. denied, 105 S.Ct. 123 (1984); Collins v. Eli Lilly Co., 116 Wis.2d 166, 342 N.W.2d 37 (1984). 6/ The difficulties plaintiffs face in attempting to show which manufacturer of a generic product was responsible for plaintiff's injury in fact can be (but are not always) substantial. While the Working Group does not advocate one approach over another, it firmly believes that any allocation of liability on the basis of market share should limit a manufacturer's liability to its specific share, and that such liability should not, in the absence of actual concerted action, be joint and several in nature.

The Working Group thus recommends elimination of joint and several liability, except in the limited circumstances where the plaintiff can demonstrate that the defendants have actually acted in concert to cause plaintiff's injury. 7/

4/ Because of a number of problems and inequities associated with Sindell, only a few states have embraced the position of the California Supreme Court. See Schwartz & Mahshigian, "Failure to Identify the Defendant in Tort Law: Towards a Legislative Solution," 73 Calif. L. Rev. 941 (1985).

5/ It is unclear whether even Sindell is a true "market share" allocation decision, since under Sindell plaintiff must only sue manufacturers representing a substantial share of the market, and may allocate all liability among those defendants in proportion to their respective market shares.

6/ Particularly disturbing are decisions such as Abel which appear to distort the principles of concerted action to impute concerted action to manufacturers of a generic product.

7/ Joint and several liability as discussed in this report should not be confused with the legislatively enacted schemes for allocating financial responsibility for the cost of cleanup of hazardous waste sites and spills under the Nation's environmental laws, and, in particular, under the Superfund Act

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Recommendation No. 4: Limit non-economic damages to a fair and reasonable amount.

Non-economic damages such as pain and suffering, mental anguish and punitive damages are inherently open-ended. 8/ They are entirely subjective, and often defy quantification. For example, in many instances it simply is not possible, no matter how much money is awarded, to compensate someone fully for the pain and anguish of the loss of a loved one or from a serious injury. Moreover, because such damages are essentially subjective, awards for similar injuries can vary immensely from case to case, leading to highly inequitable, lottery-like results. Accordingly, such damages are particularly suitable for a specific limitation.

The open-ended nature of such damages makes them a particular problem from the standpoint of achieving predictability. Unlike economic damages (medical expenses, lost earnings, etc.), which can be reviewed objectively and thus can be predicted within a given range, non-economic damages are entirely subjective and unpredictable.

Non-economic damages also can serve as a significant obstacle in the settlement process. Plaintiffs and defendants often can

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7/ (FOOTNOTE CONTINUED)

(the Comprehensive, Environmental Response, Compensation and Liability Act of 1980) and the Resource Conservation and Recovery Act (RCRA). Unlike the tort system, which is intended to compensate injured persons and to deter wrongful conduct (see Chapter 2), Superfund and RCRA represent a legislative choice to allocate the cost of these programs among those who contributed to the problems the programs are designed to remedy. Thus, Superfund and RCRA liability, like the liability established under other environmental laws, are founded upon congressional objectives which provide that those who contributed to the problem or profited from the manufacture which created the waste, ought to bear the cost of cleaning it up. Those whose specific contribution to the site can be identified and severed from the whole are not jointly liable under this scheme. Without some degree of joint and several liability under Superfund and RCRA, the effective enforcement of these programs could be seriously impeded as a result of protracted and costly litigation among responsible parties over the precise allocation of cleanup costs.

8/ There are two types of non-economic damages: compensatory (pain and suffering, mental anguish, etc.) and punitive (sometimes called exemplary damages). The latter are designed purely to punish the defendant.

agree quickly on the amount of economic damages, but disagree sharply on non-economic damages. Plaintiffs frequently have unrealistic expectations of non-economic damages in the hundreds of thousands or millions of dollars to which defendants simply are unwilling to agree. Plaintiffs thus often reject settlement offers that from the standpoint of compensation for economic damages are quite reasonable. Plaintiffs' attorneys also often see high non-economic damage awards as necessary to justify high contingency fees, which may lead them to press for a high non-economic damage award when it may be in their clients' interest to obtain a quick and fair settlement.

Nevertheless, plaintiffs should be entitled to reasonable compensation for their pain and suffering and mental anguish. The key in this regard is to provide such compensation, but to ensure that it will be kept within reasonable bounds.

The Working Group believes that $100,000 would be such a reasonable limitation. In this regard, it should be noted that only a handful of claims involve non-economic damages in excess of $100,000. For example, it is estimated that only 2.7% of all medical malpractice claims (5.6% of all paid medical malpractice claims) receive non-economic compensation in excess of $100,000. 9/ However, in those medical malpractice cases going to verdict where non-economic damages above $100,000 are awarded, the non-economic damages award averages between $428,000 and $738,000 (the latter figure being the "best estimate"). 10/ For such awards including non-economic damages in excess of $100,000, on the average 80% of the total award is for the non-economic damages component of the award. 11/ Since the non-economic damages in excess of $100,000 awarded in these cases (including verdicts and settlements) account for between 28% and 50% of all paid out medical malpractice damages, the non-

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9/ H. Manne, Medical Malpractice Policy Guidebook 132-48 (1985). In comparison, approximately half of all claims that end in a jury verdict in favor of plaintiff include a non-economic damages award in excess of $100,000. Id. This suggests that non-economic damages are a major factor in forcing claims to trial.

As discussed in Chapter 2, the Guidebook was prepared for the Florida Medical Association. Henry Manne served as the general editor, and the analysis on the effect of a $100,000 cap was prepared by Patricia Danzon -- "perhaps the most widely known and published economist in the country on the subject of medical malpractice." Id., at 10.

10/ Id.

11/ Id. In this regard, it is worth noting that non-economic damages as a percentage of overall damages increases substantially as the overall damages increase. Id., at 138-39. See discussion in Chapter 2.

economic damages payments in excess of $100,000 alone account for up to half of all medical malpractice damages. 12/ Thus, a $100,000 limitation on non-economic damage awards would affect only a relatively small percentage of all claims, but would introduce substantial predictability into the tort system. 13/

It also is necessary to deal with punitive damages. While some thought was given to an absolute ban on punitive damages, or perhaps a separate limitation, the Working Group concluded that the best approach would be to include punitive damages within the $100,000 limitation on all non-economic damages. Nevertheless, punitive damages should only be awarded for willful conduct bordering on a criminal violation. Specifically, the Working Group recommends that an award of punitive damages be predicated on a demonstration of actual malice.

Even if these recommendations are adopted, punitive damages at best have a tenuous basis in tort law. Increasingly, there has been growing skepticism among legal scholars about the role of punitive damages, 14/ and numerous instances of extraordinary

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12/ Id. The best estimate of the Guidebook is that pain and suffering awards above $100,000 account for nearly 39% of all medical malpractice damages.

13/ Some states have struck down such limitations on constitutional grounds, primarily on the basis of equal protection, on the theory that it is unfair to limit the recoveries of certain plaintiffs (e.g., medical malpractice claimants) while allowing other plaintiffs to receive unlimited recoveries. Recently, however, both the California Supreme Court and the Court of Appeals for the Ninth Circuit upheld such a limitation for medical malpractice verdicts awarded under California law. See Fein v. Permanente Medical Group, 38 Cal.3d 137, 695 P.2d 665 (1985); Hoffman v. United States, 767 F.2d 1431 (9th Cir. 1985). The Supreme Court refused to hear either case, finding with regard to the former that no substantial federal question was presented. Constitutional concerns such as this, however, can only be sensibly considered in the context of specific legal proposals.

14/ See, e.g., Owen, "Problems in Assessing Punitive Damages Against Manufacturers of Defective Products," 49 U. Chi. L. Rev. 1 (1982); Seltzer, "Punitive Damages in Mass Tort Litigation: Addressing the Problems of Fairness, Efficiency and Control," 52 Fordham L. Rev. 37 (1983); Sugarman, "Doing Away With Tort Law," 73 Calif. L. Rev. 555 (1985); Schwartz, "Deterrence and Punishment in the Common Law of Punitive Damages: A Comment," 56 S. Cal. L. Rev. 133 (1982); Ellis, "Fairness and Efficiency in the Law of Punitive Damages," 56 S. Cal. L. Rev. 1 (1982).

abuses. 15/ Punitive damages add considerable uncertainty, and frequently have very little real deterrent effect because they are awarded years after the offending conduct. In any event, the punishment of misconduct is primarily a function of the public law enforcement system, and should not be a common purpose of private litigation.

Nevertheless, the Working Group does not recommend prohibiting punitive damages in tort cases provided they are included within the limitation on non-economic damages. If this is infeasible, the Working Group recommends that punitive damages be abolished. 16/

Recommendation No. 5: Provide for periodic payments of future economic damages.

Traditionally, a losing defendant is required to pay all of plaintiff's future damages in one lump-sum payment. When damages were within reasonable limits, this generally was not a major problem. But as average damages have skyrocketed into the hundreds of thousands of dollars this has become an increasing burden on the defendant (or defendants' insurers). The Working Group, therefore, recommends that future economic damages be paid periodically. 17/

Allowing defendants to pay for plaintiff's damages periodically has several advantages. First, it gives defendants the ability in some cases to digest major adverse judgments by spacing

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15/ One of the most flagrant examples is the $8 million-dollar punitive damage award against the defendant in Johnson v. American Cyanamid Co., (District Court No. 81 C 2470), for its decision to produce the Sabin rather than the Salk polio vaccine. Despite the fact that the defendant had complied in this decision with the well established medical judgment of the United States government and virtually the entire medical community, the jury apparently decided to use punitive damages to overrule this judgment and to force the Sabin vaccine off the market. Ironically, the Sabin vaccine has proven far more effective than the Salk vaccine in combating polio. The case presently is on appeal to the Kansas Supreme Court, and the federal government has filed an *amicus* brief urging reversal.

16/ It frequently is noted that the deterrent effect of punitive damages could be achieved through a system of civil fines.

17/ Where there is legitimate concern that a particular defendant may not be able to make the periodic payments in future years the court should be empowered to require the defendant to ensure the periodic payment through the purchase of an annuity.

payments out over time, much in the same way that many consumers can afford major purchases by buying on installment. Second, society is benefited by the fact that plaintiffs have a guaranteed stream of income, and cannot deplete their awards within a few years. This sharply reduces the possibility that severely injured plaintiffs eventually will become wards of the state.

An important additional advantage of requiring courts to award damages in terms of periodic payments rather than lump-sum awards is that it uses the market's rather than a court's assessment of the applicable interest rate. Under the existing practice in most states, the trial court determines plaintiff's economic loss over plaintiff's lifetime, and then awards plaintiff the present value of those losses in a lump sum. The interest rate used to make that present value calculation is critical, and can significantly reduce or inflate the lump-sum payment. Frequently, courts in making that calculation use interest rates that bear no reasonable relationship to what in fact is available in the market.

A periodic payment requirement effectively avoids this problem by having the court determine the stream of future economic losses and require defendant to purchase an annuity providing a corresponding stream of compensation (where defendant is sufficiently large, an actual annuity probably would be unnecessary). Under such a procedure, the market determines the appropriate interest rate for calculating the present value of those payments (the present value would equal the cost of the annuity). Since the payments are guaranteed through the annuity, subsequent changes in the interest rate would have no effect on plaintiff's compensation. Defendant, on the other hand, would have the market rather than a judge or jury determine the correct interest rate for assessing the present value of future damages.

Periodic payments, as noted, are not unfair to plaintiffs because the payments would be scheduled to be made as the damages are in fact incurred (that is, as earnings are actually lost, or as certain expenses actually occur).

Because the benefits of such a provision would be relatively limited for smaller awards, the Working Group recommends that periodic payments only be required where the total economic damages award exceeds $100,000.

Recommendation No. 6: Reduce awards by collateral sources of compensation for the same injury.

The collateral source rule prohibits the finder of fact from taking collateral sources of income related to the same injury into account in making an award of damages to the plaintiff. This effectively permits the plaintiff to obtain double recovery of certain components of his damages award.

In an era when collateral sources of income were financed largely by plaintiff himself, the collateral source rule may have been sensible. Today, however, when many collateral sources are provided or subsidized by the government or by third parties (such as employers, who often are required by law to provide certain collateral benefits), the traditional justification is called into question. Increasingly, the collateral source rule simply permits a windfall recovery by the plaintiff.

As to publicly provided collateral sources of compensation, there is no justification for not taking such sources into account in determining plaintiff's ultimate damages. The collateral source rule in such circumstances has the effect of requiring citizens to pay compensation twice -- once as taxpayer, and once as the consumer of the product causing the injury. 18/

The situation is somewhat more complicated in dealing with private sources of collateral compensation, particularly where subrogation is involved. 19/ Where a third party (such as an insurer) is subrogated to plaintiff's claim, the collateral source rule may not in fact result in any double recovery. As a practical matter, however, subrogation often is not a significant consideration in many tort actions. In some areas, such as automobile accidents, subrogation is quite common. In other areas, however, such as medical malpractice, subrogation is far less common.

As to private sources, the best approach appears to be to require collateral sources of compensation related to the same injury to be taken into account as long as a third party is not subrogated to that portion of plaintiff's claim. Further analysis may suggest that elimination of subrogation (that is, simply offsetting all collateral sources against the award, and prohibiting subrogation arrangements) may have a limited effect and be justified on the basis of significant reductions in transaction costs.

While the correct approach to workers' compensation benefits must be considered very carefully, workers should be required to seek their workers' compensation benefits where appropriate. The Working Group takes no position on whether subrogation and indemnification actions between employers and manufacturers

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18/ Another reason to be concerned about such a windfall is that much of the windfall is in fact a windfall for attorneys in the form of attorneys' fees.

19/ In the context of insurance, subrogation allows the insurer to obtain from the tortfeasor-defendant all or part of its payments to the insured-plaintiff arising from the injury caused by the tortfeasor.

found liable as third party defendants should be eliminated, as has been proposed in some legislation. The Working Group will continue to review the merits of proposals dealing with such subrogation and indemnification actions.

Recommendation No. 7: Schedule contingency fees.

Currently, plaintiffs' attorneys receive a flat percentage of their clients' awards, usually between 30% and 40%, but sometimes as high as 50%. Where plaintiff's award is moderate, such a contingency fee may, in fact, be quite reasonable, since the attorney has significant costs and may face substantial risks that must be reimbursed. But as the average plaintiff's verdict has increased in recent years, such a high percentage becomes difficult to justify. Increasingly, there are indications of extraordinary abuses where attorneys receive fees in the hundreds of thousands of dollars for limited work. Particularly in mass liability cases where the groundwork for liability has been laid in previous cases by other attorneys, the fees often bear no relationship whatsoever to the work of or the risk to plaintiff's attorney. 20/

Nevertheless, the Working Group does not recommend, as some have suggested, the abolition of contingency fees. Often, such fees are the only means available to the poor to afford an attorney and obtain access to the legal system. The problem with contingency fees emerges when awards become very high, and a flat contingency rate becomes excessive. The Working Group, therefore, believes that contingency fees should be scheduled to decrease as awards increase.

Specifically, the Working Group recommends the following schedule: 25% for the first $100,000, 20% for the next $100,000, 15% for the next $100,000, and 10% for the remainder. Thus, for an award of $500,000, plaintiff's attorney would receive $80,000 rather than $166,666 (assuming a one-third contingency fee), and for an award of $1,000,000, would receive $130,000 rather than $333,333.

There are a number of justifications for scheduling contingency fees:

- Verdicts often are inflated by judges and juries to compensate plaintiff for what is well understood to be high attorneys' fees. Defendants thus pay for such fees through higher insurance premiums or awards,

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20/ As discussed in Chapter 2, the prevailing plaintiff is not only liable to his attorney for the agreed to contingency fee, but also for litigation expenses. Such expenses often can amount to an additional five to eight percent of the underlying award.

which, in turn, are passed on to consumers through higher prices. It is difficult to justify placing such a burden on American consumers for the purpose of paying what often amounts to exorbitant attorneys' fees.

- Similarly, in order to compensate plaintiffs for very high contingency fees, settlements often are higher than otherwise would be the case. As with high awards, these payments ultimately are passed through to the consumer. More problematic, however, is that attorneys' fees often can become a major impediment to settlements since defendants may balk at paying a higher than justified award in order to compensate plaintiffs for exorbitant attorneys' fees. In such situations, attorneys' fees create an additional burden by causing cases not to be settled that otherwise would be settled.

- Contingency fees also distort the incentives of attorneys. Such fees may lead plaintiffs' attorneys to hold out for high non-economic damages (and, potentially, windfall profits for the attorney requiring only minimal additional work on the attorney's part), while the clients may be best served with obtaining economic damages and more limited non-economic damages as promptly as possible.

- Scheduling contingency fees also should substantially reduce the excessive transaction costs presently plaguing the tort system. This is particularly important in such areas as the asbestos litigations where there are only limited resources available to compensate a large pool of plaintiffs.

In this regard, it is worth noting that the Federal Tort Claims Act contains a 25% cap on attorneys' fees for lawsuits filed under the Act, and a 20% cap on attorneys' fees for settlements obtained under the Act's administrative claims process. 28 U.S.C. § 2678. Violations of these limitations are punishable by fine or imprisonment, or both. A similar 25% attorneys' fee cap (with similar sanctions) is found in the Social Security Act. 42 U.S.C. § 406. None of these caps appears to have had any significant effect on the ability of persons suing the government to obtain adequate legal representation. In fact, the number of lawsuits filed under both the Federal Tort Claims Act and the Social Security Act has increased substantially in recent years.

The Working Group has considered and recommends against the adoption of the English Rule on attorneys' fees, which would transfer attorneys' fees to the losing party. While such a rule might deter some frivolous litigation, it also would inhibit many lawsuits that may be merited but where some preliminary discovery may be necessary to determine the strength of plaintiff's claims. Moreover, because many plaintiffs essentially are judgment proof, the widely held belief that such a rule would significantly deter frivolous litigation may be largely illusory.

A preferable (but still problematic) alternative approach to the English Rule would be to use a transfer of attorneys' fees as a means of motivating parties to settle their claims at an earlier point in litigation. Thus, a rule modeled on Rule 68 of the Federal Rules of Civil Procedure, 21/ but including attorneys' fees, might be useful. Perhaps the most promising approach would be to combine alternative dispute resolution with a transfer of attorneys' fees.

Recommendation No. 8: Develop alternative dispute resolution mechanisms.

The Working Group believes that alternative dispute resolution holds much promise. Experimentation and experience, however, is the only reliable vehicle for determining which systems will work. Alternative dispute resolution proposals range from binding arbitration to mediation, and include such procedural innovations as mini-trials and expedited discovery techniques. Many of these proposals are worthy of serious consideration, and states represent excellent laboratories in which to develop and explore these various alternative dispute resolution proposals.

The Working Group strongly supports alternative dispute resolution, and believes that the organized bars, legislatures, and jurists should be more receptive to alternative dispute resolution proposals. Where necessary, particularly in areas such as medical malpractice, states should be encouraged to consider seriously the necessary constitutional changes to permit the use of alternative dispute resolution.

The Working Group believes that the most promising use of alternative dispute resolution will be to encourage the early settlement of lawsuits. For example, requiring non-binding arbitration where part or all of attorneys' fees shift to the party which rejects an arbitration award and obtains a less favorable result in litigation, much as costs of litigation are shifted for rejected offers of settlement under Federal Rule of Civil Procedure 68 (see supra), might be an effective means

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21/ Rule 68 ("Offer of Judgment") provides that costs of litigation will shift to a plaintiff who has rejected an Offer of Settlement made under the rule and not obtained a judgment more favorable than the rejected offer. There currently is a proposal under consideration to include attorneys' fees in Rule 68, as well as to make other changes to the Rule. Inclusion of attorneys' fees in Rule 68, however, has a number of serious problems that must be considered very carefully. These and other problems have led the Department of Justice to caution against the proposed changes to Rule 68.

for using alternative dispute resolution to facilitate and expedite early settlements.

The Working Group does not believe, however, that alternative dispute resolution needs to or should involve major changes to the standards of liability or causation in tort law. The merits of alternative dispute resolution are largely unrelated to which standard of liability is used in resolving disputes. The value of alternative dispute resolution lies in procedural rather than substantive changes in the law.

CHAPTER 5

GOVERNMENT INSURANCE: A NON-SOLUTION

The growing liability insurance availability/affordability crisis has spawned calls for government insurance or indemnification for persons or companies unable to obtain adequate insurance coverage through the private sector. For the reasons discussed below, such government insurance or indemnification would be highly undesirable and would do nothing to remedy the problems underlying the availability/affordability crisis.

The most serious deficiency with the various schemes for government insurance or indemnification is, as noted, the fact that such proposals do not address the problems that have led to the availability/affordability crisis. Instead, these schemes simply would pass the costs of the crisis directly to the taxpayer. While it is difficult to estimate the potential cost of such a program to the American taxpayer, it should be noted that the insurance industry suffered an estimated $25 billion underwriting loss in 1985 (see Chapter 2). This loss does not include self-insurance or captive insurer losses, which in all likelihood represent additional billions of dollars.

A government insurance or indemnification program would by definition certainly involve the riskiest activities; that is, those activities that even the insurance industry is unwilling to underwrite. To the extent that the government attempts to address affordability problems by offering coverage more cheaply than the industry, the government, of course, simply would be subsidizing certain purchasers of insurance. Again, the cost of such subsidization is difficult to estimate, but considering that the insurance industry paid out over $126 billion in 1985, with related expenses of $37 billion (see Chapter 2), such a subsidy easily could involve tens of billions of dollars annually. 1/ (Again, these figures do not include self-insurance or captive insurers).

Government insurance or indemnification would not only pass these costs to the taxpayer, but could exacerbate the current problems of the tort system. One of the few constraints left in tort law is the recognition that "deep pockets" are not after

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1/ For example, over recent years the National Flood Insurance Fund has been subsidizing flood insurance by roughly $150 million annually. The cumulative loss for the program to date is approximately $1.4 billion. The President, in his latest budget submission, reiterated his intention to continue to phase out this costly subsidy. The riot insurance program, which existed from 1968 to 1984, was able to sustain itself through collected premiums. The relative success of the program, however, was largely due to the decline in urban riots after the program was instituted.

all bottomless -- that there is a finite amount of resources that can be reallocated through tort liability. Government indemnification or insurance would remove that last restraint, since the resources of the Federal Government are all too often viewed as without limit. Thus, courts and juries might be even more willing to skew liability and causation standards to ensure compensation, and to award the most generous compensation conceivable.

There are, however, a number of compelling reasons for rejecting the concept of government insurance or indemnification other than because of its potential cost and the failure to address the real problems underlying the crisis. Perhaps foremost among those reasons is that such a program would most likely jeopardize among the most effective and important mechanisms currently existing in the private sector to protect public health and safety. The insurance industry plays a vital role in promoting public health and safety by policing insureds to ensure that risks of injury are minimized. Insureds who fail to minimize such risks, or who experience higher than normal claim rates, may find the desired level of insurance coverage more difficult to obtain and more expensive. The insurance industry thus plays an important role in creating incentives that protect public health and safety, both in policing insureds, and in passing the benefits of safety back to the insureds through lower premiums.

While the role of insurance in promoting public health and safety is by no means perfect, and the above description admittedly is somewhat idealized, insurance creates important health and safety incentives which cannot be dismissed lightly. This critical function of insurance is undermined to the extent that the government supplants the private sector in providing insurance or indemnification, particularly for high risk activities. The government, even if and when it demonstrates the best of intentions, simply does not have the resources, experience, flexibility or incentives to replicate the activities of the private sector in policing insureds' practices and setting premiums to reflect claims experience. In addition, were the government to undertake such activities, the existing health and safety bureaucracies almost certainly would prove inadequate. Substantial additional funds, personnel and resources would need to be devoted to these activities, and in many areas new bureaucratic structures would need to be established. 2/ If, as seems likely, such additional investments of government resources are not made, government insurance or indemnification would operate as a clear disincentive to greater safety since insureds would receive

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2/ The necessary collection and analysis of relevant information would of itself be a major undertaking requiring substantial investment of additional government resources.

the benefit of a risk transfer to the government (and, accordingly, would have less incentive to protect public health and safety) without any corresponding checks upon their conduct or activities. Both the consumer and the taxpayer would be the ultimate losers.

To the extent that the government institutes an insurance or indemnification program, such a program also would increase significantly in two ways the involvement of the government in the private sector. First, while the government, as noted, cannot replicate the efforts of the insurance industry, it would have to become involved in the activities it has insured or indemnified to ensure that such insurance or indemnification does not lead to completely open-ended liability on the part of the government. This necessarily would involve new additional forms of government supervision and regulation of private sector activities.

A second undesirable but inevitable effect of such a program would be that the government frequently would be forced to manage, or at least actively oversee, the litigation of cases involving the liability of its insureds, since the insureds often would have only a limited incentive to contest aggressively claims, however meritless, against which they are fully insured or indemnified. Even putting aside the consideration of the massive investment of litigation resources that would be needed by both the insuring agencies and the Department of Justice, this could involve the government directly and actively in some of the most controversial and visible tort litigation in our society, much of which would involve litigation in state court under substantive, procedural and evidentiary rules of state law.

An additional consideration is that such a program necessarily would involve the federal government in state regulation of the insurance industry since such regulation could have a significant impact on the kind of insurance or indemnification the federal government would have to provide. For example, state regulators who might wish to avoid approving politically unpopular rate increases or policy provisions might be far more inclined to withhold such approvals if they perceived the federal government as ready and willing to provide an alternative source of insurance. The federal government, in turn, in order to avoid such wholesale transfers of the insurance burden, could very easily find itself compelled to regulate the insurance industry directly, or to regulate the state regulators. Either way, it would represent a substantial intrusion by the federal government into the regulation of the insurance industry.

Finally, a federal program of insurance or indemnification would interfere with and perhaps severely inhibit the ability of the market to devise new policies, insurance mechanisms, and specific contractual provisions to meet changing economic and social conditions. Where the current services of the insurance industry prove inadequate or unacceptable, insurers and insureds have strong incentives to restructure those services so that the needs of the marketplace can be met (witness, for example, the current discussions over the introduction of claims-made policies and the inclusion of defense costs). Where government insurance or indemnification is available, however, insureds may be far more inclined to seek such insurance (particularly where it is subsidized, either intentionally or unintentionally) than to negotiate with insurers or invest considerable effort and resources shopping for better conditions. Insurers, in turn, who may feel themselves compelled to offer otherwise unattractive services to customers they wish to retain, may find a government insurance or indemnification program a convenient dumping grounds for the risks they would rather spin-off. 3/ The end result could very well be that the ability of the marketplace to respond to new conditions with innovative solutions could be severely chilled if the "safe harbor" of government insurance or indemnification were available to both the insureds and the insurers. 4/

In sum, government insurance or indemnification would be a highly undesirable and counterproductive response to the current availability/affordability crisis. It effectively would amount to the nationalization of a potentially large portion of one of the Nation's leading financial industries. And, given the history of past government involvement in the private sector, it is all too apparent that removing the federal government from the insurance industry once the purported justification for its presence had passed would be an arduous if not ultimately futile endeavor.

3/ Such risks most likely would include the type of long-latency, catastrophic risks endemic to toxic torts. As is apparent from the asbestos litigations, such insurance would expose the taxpayer to potentially massive liability. The problem of insurers spinning off certain types of business very likely would generate pressure for some form of federal regulation of such practices.

4/ It should be noted in this regard that the contractor indemnification provision which the Administration supports in the context of Superfund reauthorization is purely discretionary in nature, is limited to cleanups under the control of the Environmental Protection Agency, is linked to a critical limitation on liability (liability would be predicated only on negligence), and would be provided only because it will be extremely difficult, if not impossible, to keep this vital program in operation without such limited and closely regulated contractor indemnification (which presumably will include both limits and deductibles).

CONCLUSION

This report contains within it a number of observations, conclusions and recommendations. The most important of these, however, for the purposes of the Tort Policy Working Group, are what this report implies as to the appropriate response of the federal government to the current crisis in insurance availability and affordability. In this regard, the pertinent conclusions are straightforward and relatively apparent.

First, tort law appears to be a major cause of the insurance availability/affordability crisis.

Second, there are a number of beneficial reforms of tort law that the federal government can support and promote in sensible and appropriate ways.

Third, to the extent that other factors -- such as the recent large underwriting losses of the insurance industry -- underlie this crisis, there is little the federal government can or should do to remedy these problems. While the contribution of these economic factors seems clear, it is likely that these problems will work themselves out in the short-term as the insurance industry restores its desired level of profitability, and as other insurance industry developments (see Chapter 3) are implemented. It seems highly unlikely, however, that these changes will substantially alleviate the crisis, particularly the affordability aspect of the crisis, without substantial reforms of tort law.

Fourth, the Working Group found nothing to support the suggestion that this crisis could be remedied through federal regulation of the insurance industry or of state insurance regulators.

Fifth, while a federal insurance or indemnification program obviously could provide subsidized insurance where insurance is unavailable or unaffordable, for many reasons (see Chapter 5) such a program would be highly undesirable and ultimately counterproductive.

In sum, tort law appears to be a major cause of the insurance availability/affordability crisis which the federal government can and should address in a variety of sensible and appropriate ways. But significant, long-term reform cannot and should not come solely from the federal government. Ultimately, state governments and courts must address the current excesses of tort law. Their active participation is essential to finding workable solutions to the increasingly debilitating problems of tort law.

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Chairman PICKLE. Well, I thank you, and I am glad to have this on the record. They are recommending changes in the tort system, and they do not say whether that should be on a Federal or State level, but they infer that should be on a State rather than a Federal level.

They do not make any comment about whether, if these recommendations were made, it would effect a reduction in insurance premiums.

If we went the route they have recommended, does the report explain whether there would be any reduction in insurance premiums as a result of these recommendations?

Ms. KUNTZ. The report doesn't get into that question at all. They do not state whether any specific tort reform measure will result in any specific reduction in premium rates or the expanding of coverage.

Chairman PICKLE. Do they list what types of insurance coverage would become available as a result of this proposed tort reform system?

Ms. KUNTZ. No, they don't answer that question. They cite the different types of problems different industry sectors have had to date, but they don't outline by lines of business the impact these reforms would have.

Chairman PICKLE. They don't say what benefits would result from the changes as to the various groups that would be affected. So whether it is malpractice or commercial liability or State and local insurance, there is no specific reference to what benefits would result from the changes?

Ms. KUNTZ. Nothing specific. They only indicate that total reforms will have some total impact on the situation.

Chairman PICKLE. As I read the report, they have also said that while the insurance companies did make money, their profit were a little less than the median for the Fortune 500, the insurance industry was not at fault at all?

Ms. KUNTZ. Yes, sir, they don't argue that today's problems are the result of the industry's pricing policies or its current financial status.

Chairman PICKLE. Well, I think this is a very interesting report by the working group. At least it serves as a basis for further consideration, though it is just a recommendation of that group to the administration.

To whom did they make that report?

Ms. KUNTZ. To the President.

Chairman PICKLE. Has the President or the administration made any comments about whether they approve of this, or have they just received it?

Ms. KUNTZ. It was my understanding that the working group gave a preliminary briefing to the President early last week, and the report, as an official document, was released on Thursday. That is when we obtained the copy. I don't think there has been any approval or final action since that time.

Chairman PICKLE. Well, did you, in the meeting with Mr. Willard, sense a feeling of urgency on his part that something be done this year, if possible, regarding these recommended changes?

Ms. KUNTZ. Yes; at the meeting last Thursday with Richard Willard, he said the reforms that the group recommended were items that needed to be addressed as quickly as possible, and, in fact, that many of them should have been addressed last year or the year before that.

Chairman PICKLE. Is there a time problem if these recommendations are put into effect on a State basis? Would there be a considerable time delay just by virtue of the procedures that would have to be followed?

Ms. KUNTZ. To the extent these recommendations are to be adopted by the States, you will have to consider the sheer amount of time that it takes for the State legislatures to convene, conduct hearings, and the recommendations enacted, also having, in some cases, subsequent effective dates.

Chairman PICKLE. Well, I thank you for this report, and I am glad to have it made a part of the record.

Any comments on the report?

Mr. ANTHONY. Mr. Chairman, I was at the briefing, I was pleased with the tone of the recommendations. And with the demeanor and the attitude and the professional way in which the chairman of that task force went about his job and went about making his recommendations.

He acknowledged a problem, but he was not an extremist off on one side. He acknowledged that there was some good and some bad. He did have a very good job balancing between not trashing the tort system but also acknowledging that it could be fine tuned, much like what Griffin Bell recommended earlier today.

I have been very critical in times past of some of the administration's approaches to problem solving. But this is one case where I would like to go on the record in saying that I think they have a task force that is trying to do a thorough job. We ought to follow up and try to continue to work with that group.

Chairman PICKLE. I hope, Mr. Anthony, you prove to be right.

Ms. KUNTZ. Thank you.

Chairman PICKLE. Now, the Chair would like the next panel: Lana Batts, John Parish, David Humphreys, the Honorable Ronald Sarasin, Norman Sherlock, and Edward Stimpson.

Lana Batts is vice president, policy, American Trucking Association.

Next would be Mr. John Parish, president of Lannom Manufacturing Co., speaking on behalf of the Sporting Goods Manufacturers Association.

Next, Mr. David Humphreys, chairman of the American Recreation Coalition.

Mr. Humphreys, I notice you said you are accompanied by Mr. Roy Muth.

Then Mr. Ronald Sarasin, our good friend and former Member of the House, representing the National Restaurant Association.

Then Mr. Norman Sherlock, president of the American Bus Association.

Then our old friend—wasn't so old when we first started out—Mr. Edward Stimpson, president, General Aviation Manufacturers Association.

We will proceed first with Lana Batts. Limit your testimony to 5 minutes, if you would.

STATEMENT OF LANA R. BATTS, VICE PRESIDENT FOR POLICY, AMERICAN TRUCKING ASSOCIATIONS, INC.

Ms. BATTS. Thank you, Mr. Chairman.

The American Trucking Association, like every other person at this table, is increasingly concerned about the insurance crisis. Adjectives like pending and upcoming are no longer useful for the crisis is here now and today for both its availability problem and affordability problem.

Unfortunately, we see no immediate solutions to the availability problem with the rapidly escalating prices.

Let me begin with one observation: the insurance crisis is not a trucking industry crisis; it is an insurance industry crisis. As such, the solutions will be found in the vagaries of the insurance industry. The insurance industry created the set of circumstances described in our full statement, not the trucking industry.

My formal testimony outlines some of the specific impacts that are affecting the trucking industry and how it is attempting to minimize the impacts.

Today, I would like to focus on four areas where government can help solve the problem.

TORT REFORM

First, we believe there must be some immediate tort reform on both the State and Federal levels. We believe that some of the areas to be considered include: limiting liability; eliminating punitive damages; reviving the concept of contributory negligence; eliminating joint and several liability; limiting the contingency fee system; and creating a mechanism for mandatory, nonbinding arbitration.

ENVIRONMENTAL RESTORATION

For the trucking industry's problems, there are several solutions which would help to alleviate the problem and must be acted upon. The first concerns the matter of environmental restoration as discussed in section 30 of the Motor Carrier Act of 1980.

Prior to 1980, spill cleanup was considered by the insurance industry as property damages and were compensated under the property damage provisions of the policy. Section 30 of the Motor Carrier Act of 1980 changed this by requiring separate coverage for damage to the environment. Unfortunately, the term "environmental restoration," as the damage coverage is referred to in section 30, has become the insurance industry's nightmare.

It has become so for two reasons: First, because of court decisions which hold insurance companies liable for acts and damages beyond which the individual policies intended to cover, and second, because DOT's definition of "environmental restoration" requires insurance coverage for potential as well as actual damages incurred.

While the court decisions did not involve trucks for transportation related activities, the combination of the courts' decisions and

Department of Transportation's definition of "environmental restoration," the insurance industry is extremely reluctant, or altogether unwilling, to provide coverage where the scope appears to be boundless.

Therefore, the insurance industry believes that the term "environmental restoration" should be eliminated from section 30 of the Motor Carrier Act of 1980. Such action would return to the traditional underwriting practice of compensating for spill cleanup under "property damage." Personal injuries resulting from a spill would continue to be covered under the "bodily injury" aspects of the mandated coverage. In other words, the public would retain the protection sought under section 30, but the risks would once again become insurable.

The trucking industry also supports eliminating the term "environmental restoration" from section 30. Let me assure this committee that the trucking industry does not intend to abandon or avoid its responsibility for damages resulting from the accidental discharge of goods being transported or the fuel used to move the vehicle, but the liability insurance we find is just so difficult to acquire.

SELF-INSURANCE

Another area needing Government attention is self-insurance. In most industries, a company has the option to be self-insured. While section 30 gives motor carriers this option, under current DOT and ICC regulations, carriers cannot avail themselves of this statute. On the one hand, the ICC allows self-insurance, but its regulations are so unrealistic and stringent that an authorization to self-insure has not been issued in over 20 years. On the other hand, DOT regulations do not permit motor carriers to be self-insured under any circumstances. This contrasts with DOT's handling of the railroad industry where self-insurance is allowed.

ATA believes that if a carrier can meet realistic requirements, it should be allowed to self-insure. Further, if a carrier meets the self-insurance requirements of one Federal agency, then other Federal agencies should recognize this same certification.

Finally, the area of investigations. In addition to the various hearings and investigations being conducted on Capitol Hill, we urge Congress to encourage the ICC to hold a public hearing on insurance, to complete its investigation of the crisis, and to publish its findings. Among the topics the ICC is investigating in the relationship of commercial auto trucks in risk assessment.

That concludes my summary statement. I want to reiterate the trucking industry must have adequate insurance at stable rates. Failure to have both would disrupt the free flowing interest of commerce upon which the Nation's economy so heavily depends. I would like to add one last thought, Mr. Chairman.

The trucking industry is one of those few industries in the country today which is required by law to have insurance. It is also required by law to have certain levels of insurance, and although by statute it can self-insure, by regulation it cannot. Trucking does not have the options that many other industries have. Therefore, we are presenting to this committee some solutions that while they will not solve the industry's problems, constitute a first major step to solving the problem.

Thank you very much.

[The statement follows:]

STATEMENT OF LANA R. BATTS, VICE PRESIDENT FOR POLICY, AMERICAN TRUCKING ASSOCIATIONS, INC.

I. INTRODUCTION

My name is Lana R. Batts. I am Vice President for Policy of the American Trucking Associations, Inc. (ATA). ATA is the national trade association of the trucking industry. Through its 51 affiliated trucking associations located in every state and the District of Columbia, as well as through its over 3,200 individual motor carrier members and 11 affiliated conferences, ATA represents every type and class of motor carrier in the country: for-hire and private; regulated and exempt.

The trucking industry employs 7.4 million people and generates annual revenues in excess of $200 billion. Each year nine million trucks log more than 140 billion miles with an overall safety record that is almost twice as good as that for automobiles. These trucks, operated by more than 260,000 American firms, haul 77 percent of the dollar value of all freight carried in this country.

The American trucking industry provides an essential transportation service to the largest economy in the world. The essentiality of our industry is illustrated by the fact that access to trucking is considered by business to be the second most important factor in deciding where to locate a new plant, ranking behind only cost of property. It is clear that practical business decisions are made in the confidence that truck transportation will be available when needed.

One of our common objectives -- yours as makers of public policy and ours as providers of a publicly available service -- is to ensure that businesses' expectations of an efficient, responsible transportation service are well-founded. These hearings give us both an essential opportunity to evaluate the proper functioning of a vital transportation industry and to address what is perhaps its currently most difficult problem: the availability of adequate insurance at a reasonable and relatively stable price.

Transportation, like so many other industries and endeavors, requires insurance to cover potential liability exposure risk factors to operate effectively. These include public liability and property damage, workmen's compensation, cargo loss and damage, and umbrella or excess coverages above the retention sometimes used by self-insurers.

II. BACKGROUND OF THE PROBLEM

The historical three to eight-year financial cycles of the insurance industry, determined mostly by interest rates and international reinsurance marketplace dynamics, are beyond the control of the trucking industry.

High interest rates and easily obtainable reinsurance fueled the most recent cycle, a "soft market" from the mid-1970's to early last year. In what is termed "cash flow underwriting," premium dollars from the writing of oftentimes indiscriminate policy coverages by primary underwriters yielded returns from 18-20 percent interest-bearing investments for several years sufficient to offset claims and still realize profits. Sound underwriting practices and effective risk management were generally ignored. It was a buyers' market. A trucking company simply called an insurance broker and got the cheapest rate.

Early last year several factors produced a dramatic turnaround: interest rates dropped by almost a half; reinsurance became expensive; "long-tailed" claims for risks that had been indiscriminately written for in the early "soft market" came home to roost, after lengthy adjudication, in the form of large court awards, particularly for pollution damage and asbestos poisoning;

several global catastrophies, such as the Bhopal incident in India and numerous aviation disasters, also had a substantial impact, as did high state insurance commission-imposed reserve requirements. In short, cash flow underwriting no longer worked for the insurance industry.

A capacity crunch resulted, a $60-plus billion shortfall in reserves. All insurance needs could not be met. The insurance companies had to recoup. Higher premium rates to increase capacity appeared to be the quick answer. Sound underwriting practices and effective risk management also became the urgent order of the day.

Limited capacity was focused on the safer, known risks. Those with what were perceived as unquantifiable, unpredictable, and/or unlimited risks were either dropped from coverage or targeted for arbitrary, skyrocketing premium rates. Hardest hit were the specialty lines of commercial insurance. Trucking found itself in the company of taxis and buses; liquor handlers; those dealing with bank surety bonds; directors and officers of municipalities and other organizations; lawyers, doctors, and accountants; and day care centers, among others. A company's safety or claims track record had little to do with premium rates and/or accessibility to underwriters.

III. SEVERITY OF THE PROBLEM IN TRUCKING

Because sound underwriting practices and risk management techniques were by and large not utilized during the "soft market," when the market turned last year there were little statistical data from which an analysis of the devastation of the trucking industry could be drawn. Risks were not quantified, or at best only marginally quantified, during the "soft market."

Hence, we are at this hearing stage knowing only, as Will Rogers would have observed, what our friends tell us and what we "see in the papers." That, however, is substantial and more than enough to paint a picture of the monumental nature of the problem.

It should be pointed out that unlike many of the others listed above who are having difficulty finding insurance coverages at reasonable rates, trucking has Federally-imposed minimum levels of coverage. What does a business concern do when it must meet mandated minimum levels of coverage that it cannot purchase? It seems to us that those who impose such minimum levels have a responsibilty to see to it that coverages for them are available -- at reasonable rates. Trucking's problem above others is that operating with no insurance coverage or coverage below the limits violates Federal law.

Following are some of the things we have learned about the severity of our problem:

- Premium rates for primary coverages for public liability and property damage (PL&PD) for general commodity carriers skyrocketed in 1985 on the average from 250 to 500 percent with no apparent connection with the experience of the insureds. In 1986, it appears they will increase another 100 percent for a two-year increase of 500 to 1,000 percent. We have had carrier after carrier tell us of claims-free records which have had no effect on the rates being quoted to them. Some have been unable to get coverage at any rate, especially the tank truck carriers hauling hazardous materials. Those in the latter category who have been lucky enough to get coverage have absorbed increases of 1,000 percent or higher.

- Workmen's compensation primary coverage premium rates have also similarly shot up dramatically. For awhile during the early stages of the "hard market" they were stable because the state insurance commissioners were holding a lid on them. But within the last eight or nine months, these officials have been forced to remove the lid as a result of pressures brought to bear on them by the insurance companies who argued that increased rates are the only means of increasing capacity and meeting reserve requirements.

- Primary coverage premium rates for cargo loss and damage liability have risen on the average 70 to 150 percent. Some trucking companies have been unable to get coverage with street rates and have had to resort to usage of assigned risk pools in their states.

- Those who have turned to the assigned risk pools in their states to obtain coverages not otherwise available have done so despite the stigma associated with such a move that presents a bad connotation to prospective shipper customers. The demand will outstrip pool funds and capacities. Many carriers have called us to tell us that the coverages they were able to obtain do not meet Federally-imposed minimums.

- While we do not know the percentage to which carriers are increasing their deductibles for self-insurance purposes, we do know that most are being doubled or tripled. Premium rates for the excess coverages beyond the primary coverages are also increasing dramatically, with the level of coverage provided substantially decreased. Most of the insurance companies who will write primary coverage will not write excess. So, many trucking companies cannot get the required levels of insurance.

- Some insurance companies are arbitrarily cancelling policy coverages in mid-term, in spite of the fact that over 30 states prohibit such actions. Several trucking companies have been successful in getting court injunctions reinstating coverage for the policy terms, for example, in Arkansas and Iowa. Apparently insurance companies have made the business and economic judgment that it is better to risk the consequences of such lawsuits than it is to forego the opportunity to use limited capacity acquired from such cancellations to write coverages at the greatly increased premium rates.

- ATA has been receiving an average of 1,000 calls per month on the insurance hot line we instituted August 6, 1985, to assist carriers in pursuing shopping leads.

- On August 9, 1985, the Interstate Commerce Commission furnished us with a list of about 700 underwriters which its files indicated are writing truck insurance. Analysis of that list indicates, however, that about 95 percent of the companies listed are writing truck coverage only incidental to the other insurance business they have with the manufacturer or shipper who has a private fleet.

  In other words, only about five percent, or 35, are in the for-hire trucking market. Unfortunately, more than 50 percent of these underwriters are in dire financial straits or are pulling out of the trucking market altogether. As a result, rather than 700, only about 18 insurance companies, as far as we can tell, are financially sound and writing for-hire truck insurance. For example, recently Carriers Insurance Company of Des Moines, Iowa, was taken over by the State Insurance Commissioner, and 5,000 trucking companies were forced to seek a new insurance company. Some could not and were forced into state assigned risk pools. One Minnesota carrier went out-of-business rather than take a 700 percent increase in the assigned risk pool.

- We do not know the number of trucking companies that have gone out of business as a result of their inability to pay for insurance. However, the trade press is full of specific instances from which we know there are many, particularly in the smaller size category. For example, the lead story in the January 7, 1985, issue of Transport Topics was about the demise of General Motor Lines of Roanoke, Virginia. The last issue of Transport Topics in 1985 described three carriers who had gone out of business -- two were the result of increased insurance premiums.

- Literally hundreds of trucking companies had filed independent tariffs with the ICC last year seeking approval of surcharges to their existing tariffs that will allow a pass through to the shippers of the increased insurance costs. The ICC is granting them routinely but is so short-staffed that the agency's employees are not even keeping running tabulations of the numbers. Hence, we do not know exactly how many have filed. The percentages sought range from 1.5 to five percent.

- * Tank truck operators have been the most severely hit. Their problems are exacerbated by the Federal government debates over environmental restoration, Superfund, and definitions of gradual pollution over sudden and accidental pollution. As this Committee perhaps knows, several courts have interpreted the fine print on insurance policies regarding gradual/sudden and accidental pollution in ways other than what we believe Congress intended. Tank carriers are experiencing rate increases close to 1,000 percent if coverage can be obtained at all.

- * Some insurance companies are nonrenewing suddenly and arbitrarily, with inadequate notice to the insureds. Such actions became such a problem in New Jersey, for example, that the Governor has declared an insurance emergency and has prohibited mid-term cancellations and nonrenewals for a six-month period.

- * Numerous unusual exclusions are finding their way into the fine print of insurance policies submitted to trucking companies. Targeted, for example, are owner/operator usages, leased equipment, driveaway operations (motorized cargo that rolls on its own wheels under a bill of lading), and hazardous materials, as examples. The problems are particularly acute in the household goods moving industry which employs the services of over 21,000 interstate owner/operators, over 20 percent of the nation's entire owner/operator population. These small, independent owner/operators, attempting to negotiate for adequate, reasonably priced insurance, face a dilemma.

- * Insurance companies are switching from occurence-based to claims made coverages for general liability. This means they will pay only if the claim is submitted during the policy period. The effort is to eliminate "long-tailed" claims. While there is no specific date when commercial auto (i.e., truck) insurance will be claims made, it will happen in the near future. In the meantime, there is the possibility that a motor carrier could have its primary coverage under an occurrence-based policy and its umbrella coverage under a claims made policy.

* ATA's own officers and directors' liability insurance premiums have increased 233 percent despite no claims ever in the history of the coverage.

If carriers cannot find insurance, they have two options: cease operations until they can find insurance or operate illegally. Unfortunately, some appear to be utilizing the second option.

ICC Chairman Reese Taylor reported to Congress in September that 3,393 carriers have had their operating authorities revoked in an 11-month period (October 1984 to August 1985) for failure to have insurance or evidence of other financial responsibility. He also reported that 15,000 others were under investigation for "insurance delinquencies" and that 482 consent agreements had been entered into whereby motor carriers agree not to engage in interstate commerce until they have adequate insurance. He said the agency had obtained 28 civil injunctions which prohibit motor carriers from operating in interstate commerce until they have adequate insurance.

The U.S. Department of Transportation reports that 25 percent of all carriers -- regulated and unregulated -- do not have adequate insurance coverage.

Cost increases in insurance and other areas are affecting truckers of all sizes and shapes, making it more expensive to operate, reducing profits, and causing operating ratios to rise. Declining profit margins, or no profits at all, are bound to have substantial negative impact upon fleet maintenance and, therefore, upon the safety of our highways.

IV. POSSIBLE SOLUTIONS

INDUSTRY

ATA has undertaken a number of activities to mitigate the effects of the current crisis and to work toward long-term solutions.

We first warned the industry about the impending crisis in January 1984 several months before the insurance market turn began to impact. Subsequently, ATA formed an Insurance Task Force composed of association staff members and carrier personnel with insurance responsibilities. The Task Force has met on numerous occasions during the past 15 months to develop recommendations for industry action. The ATA Executive Committee has acted upon those recommendations four times. A list of ATA activities is attached.

Since the crisis is an insurance industry problem that is international in scope and trucking is just a small portion of those affected, easy short term solutions are simply not available. Therefore, the Task Force concentrated on (a) short-term efforts to ease the crisis and (b) in-depth study of possible long-term solutions.

Among the short-term efforts were two educational "How to Cope..." seminars for the industry were held in May and October of 1985 utilizing state-of-the-art-versed nationally known and recognized experts. The consistent message from various speakers was that motor carriers must take determined action to avoid, prevent or reduce the risk of losses -- action ranging from safety programs to researcing their records and implementing effective risk management. Five more such seminars with the same message were given in February.

Another short-term effort has been directed toward providing assistance to carriers in obtaining coverage. Many carriers are out of practice in "hard market" shopping. ATA staff members had been reacting to their calls for shopping leads for at least twelve months on an informal basis when in August 1985 we formalized the service with the "Insurance Hot Line" mentioned above which is averaging 1,000 calls per month. In addition to providing shopping leads, we offer referral to professional outside help where shopping has been attempted and complex and difficult problems remain.

A third area of activity has been directed toward the pass through or surcharge for carriers of dramatically increased insurance costs mentioned above. For example, ATA's then Chairman of the Board, Dale Craig, filed the first insurance surcharge with the ICC on July 15, 1985. Since then many more carriers have filed similar surcharges.

Additionally, the ATA on December 17, 1985 joined American Tort Reform Association. The group is dedicated to seeking state tort law reform. ATA was also a founding member of the Coalition for Insurance Availability, formed December 9, 1985.

Other mitigation efforts, some of which are occurring at the state association level, involve assigned risk pools, class action suits for mid-term cancellations, and challenges to the legality and reasonableness of premium rate increases, among other matters. Many truckers and state associations have made recent contact with state insurance commissioners.

With respect to long-term efforts, the ATA Insurance Task Force has realized that before intelligent decisions can be made and/or recommendations made, in depth hard data are needed. Such data are required before we can pursue the setting up of any endorsed group program and/or a captive insurance company, two options under discussion that would increase capitalization in the insurance industry and, therefore, its capacity. Pitfalls with respect to either, but especially regarding the latter, are abundant. How would they have any more success in attracting reinsurance at reasonable rates in international markets than those companies presently trying to get it? Can premium rates for primary insureds in trucking be made competitive in today's market conditions when the risk is spread only among those in one industry? Even if so, could they continue to be competitive and produce financial solvency for the group plan/captive when the next cyclical "soft market" arrives? We must have hard data to make intelligent decisions about such options and/or pursue other possible solutions via government entities.

GOVERNMENT

Solutions to the overall insurance crisis may lie in reform of our tort system. ATA is on the steering committee of the American Tort Reform Association (ATRA). On February 21, 1986, James Coyne, Executive Director of ATRA, testified before the House Judiciary Committee and suggested several areas where tort reform was necessary, including:

- Limiting liability;
- Eliminating punitive damages;
- Reviving contributory negligence;
- Limiting contengency fees; and
- Creating a mechanism for mandatory, nonbinding arbitration.

We support these suggestions. A copy of Mr. Coyne's testimony is attached.

For the trucking industry's specific problems, there are several solutions which would help to alleviate the problem and must be acted upon.

Environmental Restoration

While all segments of the trucking industry have been impacted, the hardest hit have been those motor carriers of hazardous materials, whose potential, or at least perceived, liability for environmental cleanup following a spill is the greatest. Since January 1, 1986, however, very few insurance companies have been offering environmental restoration coverage, even though trucking companies are Federally-required to have this insurance as a precondition of transport.

Prior to 1980, spill cleanup was considered by the insurance industry as property damages and were compensated under the property damage provisions of the policy. Section 30 of the Motor Carrier Act of 1980 changed this by requiring separate coverage for damage to the environment. Unfortunately, the term "environmental restoration", as the damage coverage is referred to in Section 30, has become the insurance industry's nightmare. It has become so for two reasons: (1) because of the court decisions which hold insurance companies liable for acts and damages beyond which the individual policies intended to cover, (2) because DOT's definition of "environmental restoration" requires insurance coverage for potential as well as actual damages incurred. While the court decisions did not involve trucks for transportation related activities, the combination of the courts' decisions and DOT's definition of "environmental restoration", the insurance industry is extremely reluctant, or altogether unwilling, to provide coverage where the scope appears to be boundless.

Another problem facing the trucking industry is a recent development. The ICC and DOT require the insurance company to file a form MCS-90, which indicates that the trucking company has adequate coverage, including environmental restoration. However, we are now seeing cases where the insurance company refuses to file this form because of the open-ended definition of "environmental restoration" printed on the form, even though the carrier has the required limits and coverages.

Therefore, the insurance industry believes that the term "environmental restoration" should be eliminated from Section 30 of the Motor Carrier Act of 1980. Such action would return to the traditional underwriting practice of compensating for spill cleanup under property damage. Personal injuries resulting from a spill would continue to be covered under the "bodily injury" aspects of the mandated coverage. In other words, the public would retain the protection sought under Section 30, but the risks would once again become more insurable.

To these beneficial ends, the trucking industry supports eliminating the term "environmental restoration" from Section 30. Let me assure this Committee that the trucking industry does not intend to abandon or avoid its responsibility for damages resulting from the accidental discharge of goods being transported or the fuel used to move the vehicle.

Self-Insurance

In most industries, a company has the option to be self-insured. While Section 30 gives motor carriers this option, under current DOT and ICC regulations, carriers cannot avail themselves of this statute. On the one hand, the ICC allows self-insurance, but its regulations are so unrealistic and stringent that an authorization to self-insure has not been issued in over 20 years. On the other hand, DOT regulations do not permit motor carriers to be self-insured under any circumstances. This contrasts with DOT's handling of the railroad industry where self-insurance is allowed.

ATA believes that if a carrier can meet realistic requirements, it should be allowed to self-insure. Further, if a carrier meets the self-insurance requirements of one Federal agency, other Federal agencies should recognize this same certification.

Federal Investigations

On August 21, 1985, the ATA petitioned the ICC to institute an investigatory rulemaking into the causes and effects of the current increases in insurance premium rates for motor carriers leading to the adoption of findings and/or rules which assist motor carriers in acquiring and maintaining the required insurance and in controlling the increased costs. (copy attached)

The investigation was formally opened on October 31, 1985, as Ex Parte MC-178. Since that time, the liability crisis has become increasingly worse. More and more insurance companies are dropping out of the trucking insurance market, thus, decreasing capacity tremendously. ATA has recently asked the ICC to hold a conference of interested parties so that carriers, shippers, and the insurance industry, as well as the Federal agencies involved, could come together an openly discuss the problem and, hopefully, find solutions. We urge Congress to encourage the ICC to hold this conference, complete its investigation and publish its findings.

V. CONCLUSION

The current insurance problem is going to get worse before it gets better. No one we talk to thinks otherwise. In fact, insurance experts tell us that reinsurance rates are likely to go up 600 to 1,500 percent after the first of the year. The impact will make today's premium rate increases for primary insureds pale to insignificance. Minnesota Insurance Commissioner Michael Hatch predicts that the current multi-billion dollar shortfall in insurance industry capacity that is leaving "roughly nine percent of the commercial lines marketed this year" without coverage will grow "to approximately 26 percent by 1987."

Apparently the current greatly increased premium rate dollars taken in by the insurance companies have had only minimal effect so far in reducing the shortfall. The risk management expert under contract with ATA reports that only about a $3 billion dollar headway in decreasing the shortfall has been made in the past year. At that pace the crisis will last well beyond 1987, the year some experts are predicting the market will stabilize.

Mr. Chairman, the trucking industry has attempted to deal with the insurance crisis separately and through coalitions. But we cannot do it alone. We need your help. That help could begin with:

- Removing "environmental restoration" from Section 30 of the Motor Carrier Act of 1980;
- Allowing reasonable self-insurance; and
- Investigating the insurance crisis.

The American Trucking Associations appreciates this opportunity to share with members of Congress the distressing developments we are experiencing with insurance. We believe that transportation, trucking, and safety are of sufficient vital concern to the nation's economy and the public that action on your part is warranted. We seek adequate insurance coverages at reasonable and relatively stable rates. Failure to deal effectively with the insurance crisis could lead to serious disruptions in the normal market forces which govern the trucking industry and ultimately interstate commerce.

ATA INSURANCE ACTIVITIES

- February 13, 1985 -- Established an Insurance Task Force, chaired by Rocque Dameo of New Jersey.
- May 20-21, 1985 -- Conducted a two-day seminar on risk management.
- July 17, 1985 -- Established an insurance hot line to match buyers and sellers of insurance.
- August 21, 1985 -- Petitioned Interstate Commerce Commission requesting investigation of insurance crisis.
- September 9, 1985 -- Requested National Association of Insurance Commissioners to investigate insurance crisis on state level.
- October 21, 1985 -- Conducted seminar on risk management.
- October 30, 1985 -- Testified before House Public Works Committee on insurance crisis.
- December 2, 1985 -- Filed comments with the Interstate Commerce Commission on its investigation of the insurance crisis.

- o December 9, 1985 -- Helped found the Coalition for Insurance Availability to increase public awareness of crisis.
- o December 11, 1985 -- Participated as a Panel member at the Liability Insurance Crisis Conference in Washington, D.C. sponsored by The Small Business Legislative Council, The Greater Washington Society of Association Executives and The Coalition of Insurance Availability.
- o December 12, 1985 -- Hosted an all-day meeting with 12 top insurance executives.
- o December 16, 1985 -- Named to Steering Committee on Liability Crisis of the U.S. Chamber of Commerce to coordinate state and Federal efforts.
- o December 17, 1985 -- Named to Steering Committee on the American Tort Reform Association.
- o January 1986 -- Conducted a series of five regional seminars on risk management throughout the country.
- o January 22, 1986 -- Testified before House Public Works Subcommittee on Investigation and Oversight on insurance crisis.
- o February 7, 1986 -- Filed comments with the Interstate Commerce Commission opposing the further elimination or proposed reduction in the motor carrier reporting requirement.
- o February 1986 -- Petitioned Interstate Commerce Commission requesting a conference on the insurance crisis conducted by a hearing officer. Such a conference will allow parties to work out solutions without talking through lawyers and legal petitions.

Future Actions

1. Early April 1986 -- publication of insurance risk management manual for trucking.
2. March 1986 -- Testify before 3 Congressional Committees on Liability insurance crisis.
3. Possible ATA endorsed insurance program for qualified members.

TESTIMONY OF JAMES K. COYNE

EXECUTIVE VICE PRESIDENT
AMERICAN CONSULTING ENGINEERS COUNCIL
AND
PRESIDENT
AMERICAN TORT REFORM ASSOCIATION

ON

IMPACT OF LITIGATION AND LIABILITY ON CONSULTING ENGINEERS AND INDEPENDENT BUSINESS

BEFORE THE
COMMITTEE ON THE JUDICIARY

ATRA
AMERICAN TORT REFORM ASSOCIATION
FEBRUARY 21, 1986

Mr. Chairman, members of the Judiciary Committee, my name is James Coyne. I appear before you today as Executive Vice President of the American Consulting Engineers Council (ACEC) and President of the newly formed American Tort Reform Association.

If justice is blind we must do something to correct her vision. Because the vision of American justice has become so distorted, that the scales have been totally tipped to the plaintiffs, and particularly, plaintiffs that can afford high priced trial lawyers. The American civil justice system, which our Chief of Justice Burger has for many years decried, is in danger of seriously damaging our way of life.

Our system of civil justice is based on a fair hearing of the evidence and redressing of wrongs. Today its become an investigation of who has insurance and inventing a legal theory to show why the insured defendent should pay. We have moved from remedy based on negligence or fault to compensation based on injury, the more unlikely and outrageous the better.

Risk for local governments, independent businesses, professionals providing essential services was something computed far down in the budget and covered by insurance. Now risk is top of the agenda at city council meetings, board rooms, and universities. It no longer is a minor budget item for insurance, but is often not only expensive, but increasingly unavailable.

But more importantly, it has put many people in the "risk" business, people who must make the decision, "Do I dare continue to serve on this board of directors, this school board or town council, this athletic or recreation league?" For many the answer is no. They have decided the risk isn't worth it. This is particularly true of small businesses, volunteer groups, local governments, and special purpose districts. That decision costs us all; not in dollars, but in the quality of our communities.

For the others who choose to take the risk, however, it changes the way they make the decisions that matter. Rather than innovation, new products, new services, new markets, public and private managers have to worry about, "What's the chance I'll get sued?" In this stifling climate of anxiety over unknown risk, our economic growth, perhaps even our spirit of adventure and pioneering, will be reduced.

How does this directly relate to consulting engineers? Our members have been consistently in the forefront of responding to the major challenges of this century. The great strides in transportation, communications, buildings, energy generation, pollution control and even historic preservation are all dependent on engineering, most of it done by independent professional firms. Yet what do we find today.

Liability insurance is today nowhere available for hazardous waste removal engineering nor for the design of the rehabilitation of federal buildings, when asbestos is present. Firms performing structural engineering necessary for construction of dams, wastewater treatment plants, bridges, as well as public buildings, experienced an average increase in premiums of 54% in 1985.

The pollution exclusion published by the insurance industry in mid 1985 may eliminate coverage for environmental firms designing pollution control systems for water and air.

But the root cause of the crisis we believe is not in the insurance industry, but the American civil justice system. Five years ago a small minority of our firms were sued by their clients to remedy design errors or by personal injury claimants. Today it is not uncommon for engineering firms to have multiple suits at all times pending. Architectural/engineering (A/E) firms in 1985 averaged 109 new claims/100 firms and 210 claims pending/100 firms.

What we have in public, as well as private and commercial projects, is a crisis in tort liability. This crisis extends to every facet of business life.

What is the crisis of our tort system? For that matter, what is tort law? For those of you who are not legal scholars, tort law is the law of civil wrongs other than the breach of contract. It's the framework for most of the lawsuits in America today.

A little historical perspective is needed to understand how we got to where we are.

There are two broad areas of the law: criminal and civil. Tort law falls under the civil category and includes everything from slip and fall cases to automobile accidents to libel suits.

The rules in tort law center on what kinds of injuries can be compensated and what has to be proved to win the lawsuit. We inherited these rules from English common law. In the past, changes in these rules evolved slowly, largely from court decisions, not from statutes.

In America, we have 50 different state court systems and hundreds of federal courts that must interpret and apply these laws. There is often a difference between the rule in one place and the rule applied in another. Overall, however, most court decisions on tort law have followed the same general trend.

Surprisingly enough, even with all the minor adjustments and additions made through nearly 200 years of American court decisions, the balance struck by English common law remained essentially the same from the early 1800s until the 1960s.

With limited exception, a person suing could recover only if he proved that the defendant was at fault--that the defendant's negligence caused the injury. If the plaintiff--the person bringing the lawsuit--was the primary cause of his own injury through negligence or deliberate conduct, he could not recover.

Plaintiffs could usually get damages for intangible pain and suffering only if there was an accompanying physical injury. And punitive damages--punishment awards over and above compensation for injury--were available only for truly outrageous conduct. In other words, tort laws were defined in such a manner that one only obtained redress for cases of true negligence, not for the personal risks of everday life.

The tort system we have today--only 25 years later--is vastly different. Our generation has overturned 200 years of legal tradition.

To illustrate recent changes, let's look at just a few of the important decisions of the last 25 years in California. I have chosen California because its lead has often been followed by other states.

In 1961, California rejected the common law doctrine of sovereign immunity, which for centuries had protected cities and states from lawsuits. In fiscal 1984, California cities--that's California taxpayers--paid out more than $19 million in claims, up from $5 million just three years ago.

In 1962, the concept of fault was tossed aside in the area of product liability. Now, an injured person doesn't have to prove any negligence--just that the injury might have been prevented by a different product design. That's how you get lawsuits against telephone booth manufacturers for not making their product crashproof.

In 1968, the California Supreme Court changed the standard of care owed by landowners, extending the duty of "utmost care" to even criminal trespassers. You can now see why a burglar robbing a school can successfully sue for injuries.

In 1975, California replaced the doctrine of "contributory negligence" with "comparative negligence." Comparative negligence allows an injured party to recover if he is partly--or even primarily--at fault for an accident.

Not only has legal doctrine been substantially altered, the dollar value of awards has ballooned. The tort system today has more million dollar winners than a state lottery. You may think that the high awards you read about are aberrations, but in 1984 the average product liability verdict was over a million dollars. The average medical malpractice award was $950,000.

Courts today also have become more liberal in awarding punitive damages. Recently, an insurance company disputed the proper settlement amount with a couple whose car was rear-ended. The insurance company offered $4,500; the couple believed they were entitled to $17,000. They sued, claiming the insurance company had failed to settle their claim in good faith, and recovered $7.4 million in punitive damages. Regardless of who was right or wrong, the punitive damages awarded were totally out of proportion to the claim at hand.

And courts in many states are handing out extraordinary awards even where there is no physical injury, just the mental trauma caused by watching an injury happen to someone else, or the worry brought on by fear that an injury might occur in the future.

Huge damage awards are a recent phenomenon. The first million-dollar tort verdict was awarded in 1961. In 1983 alone, this country settled 360 cases for $1 million or more. By comparison, in the entire judicial history of Canada, there have been only six $1 million tort cases--and three of those cases, applying Canadian law, were decided by U.S. courts. No other country pays these huge amounts.

The financial cost of our tort reparations system is staggering: In 1984, the tort system was estimated to cost 37 times as much as it did in 1950. Commercial liability insurers alone spent $2.9 billion defending suits in 1983; and legal defense costs had risen to 25 cents per premium dollar, compared with 5 cents per dollar in the 1950s.

Think of it instead as the dean of Stanford Law School did -- as litigation pollution, or more precisely, as a disease dramatically weakening our nation.

It's a disease with 16.6 million lawsuits in America last year (Japan had less than 1% as many). It is a disease which consumes as much as $60 billion of our GNP, and wastes some of America's finest minds, best products, most successful research and production facilities and saps the creativity and energy of our public and private enterprises. And it's a uniquely American disease. Two thirds of the world's lawyers are in the U.S.

What are the symptoms? Such lawsuits occur everywhere -- sometimes for the most frivolous reasons. They are reported in any newspaper almost any day and liability awards from these suits show no relationship with fact, fault or fairness. The acute symptom of the disease is a plague of insurance policy cancellations and premium increases.

Most of the 1986 policy renewals among our members for liability insurance show increases from 50 to 900%. Furthermore, almost everyone's deductibles are being doubled and limits of liability are being reduced.

The consequences for hazardous waste cleanup engineers, as we described above, as well as nurse-midwives, day care centers, asbestos removal contractors, ski areas, small towns and community colleges, LP gas distributors, new drug companies, landfill operators and thousands more, are they have to go bare -- no one will write insurance at any price. They're facing bankruptcy, liquidation or the deadly game of litigation roulette. More than 13% of all ACEC firms went "bare" in 1985, but more sadly 1 in 3 of all of our smallest firms either cannot afford or cannot obtain liability insurance. As a result, the public is unprotected, as well as these independent businesses.

We're here today to introduce ATRA. We want to find a cure to this disease. We feel that basic tort reform is the only answer, together with a fundamental change in public attitude toward tort litigation. ATRA is the first and only national association to join together a broad army of public and private organizations to fight this litigation pollution. As you can see, we include professionals and trade associations, some of the biggest and some of the smallest. Our charter member organizations represent more than 960,000 businesses, professionals, schools, communities, partnerships and public entities. Collectively, they employ more than 19 million tax paying Americans. And we expect more than 200 other associations to join within 30 days. We are all committed to curing this disease, lowering liability premiums, litigation expenses, and reducing the frequency of unjust and irrational lawsuits. We have a two-pronged agenda. First, build a broad-based bipartisan public organization with the resources and capabilities to demonstrate to our nation's policymakers what has to be done. Many lawmakers hear only the voice of the Association of Trial Lawyers of America (ATLA). In fact, the multi-million dollar war chest they've raised to oppose tort reform demonstrates how their own self-interest is leading them to ignore their duty to the public.

Second, we intend to carry this effort to 50 state capitals this year. Tort reform will not come only by the efforts inside Washington's beltway. It will be the #1 issue in at least 40 state legislatures this year. We stand ready to support these state efforts, especially with the help of the American Legislative Exchange Council, the leading organizations of state legislators concerned about tort reform.

Of course, national leadership is forthcoming. Attorney General Meese has created a special Working Group within the Domestic Council to propose tort reform proposals. Ass't. Attorney General Willard calls tort reform his #1 priority.

The membership of ATRA spent an afternoon at the White House just two days ago to air our concerns and explore ways we can help achieve our goals.

Chief Justice Berger tells the story of a small town with only one lawyer who is about to close up shop for lack of business. But then another lawyer moves in -- now both are thriving. The Chief Justice has called for tort reform and the Judicial Conference, which he chairs, is actively reviewing several proposals.

Of course, Congress, too, will hold hearings. We believe it fitting that the Judiciary Committee, which is responsible for the nations's court system and federal legal structure, is the first

Senate Committee to hear the ATRA message. Tort reform will certainly be an important item on the Congress' agenda this year.

The battle has begun. Much has to be done. The public needs to get a better understanding of how the arcane subject of tort law so severely affects their lives and their livelihoods.

We are confident of the success of our effort because of the broad public and private support and interest we have already received. We are confident that our friends in Congress will be interested and committed to join us in this effort.

What is the solution? We can't look to the lawyers to solve the problem. Abraham Lincoln, a lawyer himself, once said that the highest duty of an attorney was to discourage litigation. While I certainly support his view, it is a tough standard. It's like asking doctors to discourage medicine or ad agencies to discourage advertising. In fact, just the opposite is happening as lawyers increasingly advertise for tort clients.

We can't look to insurance companies to solve the problem. As middlemen, insurers are in the business of spreading risks in a society, not picking up the tab for them. Insurance is unusual in that it must price its product to cover the cost of lawsuits today and many years into the future. As long as the courts define the rules, the policies will be competitively priced to reflect those rules. If the liabilities are undefined, the insurance cannot, or should not, be written.

Finally, we can't look to the courts alone to solve the problem. Courts are focused institutions which decide narrow cases involving the parties before them. Only occasionally do they see repercussions beyond the immediate case. If they did, they would probably not have set many of these recent precedents.

It took 25 years of case-made changes in doctrine to create our most litigious society in the world; but we do not have 25 years to correct it. The stakes are simply too high. So, if we can't look to the lawyers, and we can't look to the insurance companies, and we can't look to the courts to solve the problem, who can we look to?

The answer lies with us as citizens and with the legislature. But the legislature will not act until the voters make their voices known. Everyone must get involved because everyone is paying the price--municipalities, businesses, citizens and even the trial lawyers, who are themselves having trouble getting liability insurance.

It is time for all of us to step back and readdress some basic questions:

- Is fault still important?
- Where do we draw the line on defining and assigning liability?
- Should there be limits on financial damages?
- When does ease of suit cripple the productive elements of society?

These questions--and others--are big, important and complex. They must be thoroughly analyzed and debated at the local, state and national levels by everybody, not just the experts. We must understand the issues. We must talk to one another. We must involve our legislators. Only then will the system begin to change.

The following are some solutions we might consider:

1. Put limits on liability.
    - Limit pain and suffering awards, particularly when there's no physical injury or when the injury occurred to someone else.
    - Reduce size of awards where the impact of taxes, expenses and collateral sources are significant.
2. Punitive damages. The original justification for punitive damages was to deter outrageous behavior, willful and wanton misconduct. In recent years, this good standard has been diluted to the point of capriciousness.
3. Revive comparative negligence. This doctrine allows plaintiffs to recover large damages even if they are more responsible for the injury than the defendant. That's what allows people who throw themselves in front of subway trains to recover hundreds of thousands of dollars from the taxpayers. It should be possible for judges to dismiss lawsuits at an early stage if the plaintiffs are clearly responsible.
4. Eliminate joint and several liability. The defendant should be financially responsible only for his own fault in the incident, and not for someone else's fault if that person can't pay.
5. Limit the contigency fee system. This encourages frivolous lawsuits and provides an irresistible incentive to extend the line on defining liability.

6. Create a mechanism for mandatory, non-binding arbitration of smaller claims , which make up the bulk of tort cases. If a plaintiff then carries his case on to the courts, he should pay defense costs if he does not prevail.

We think that the Alternative Dispute Resolution Act and the Litigation Abuse Act are two steps in the right direction. We urge the Judiciary Committee to become the Senate leaders for tort reform. Pieces related to specific professions or remedies have been introduced elsewhere but this is the Committee where the leadership focus should be.

Someone once said that people get the kind of government they deserve. In a democracy, it's also true that we get the kind of civil justice system we deserve.

I think we deserve a system that is predictable. A system that provides prompt, just and full compensation to injured victims at a reasonable cost. A system that does not make each of us a potential target for lawsuits arising from someone else's accidents. A system, in other words, that does not outrage our common sense notions of justice.

Thank you for the opportunity to present our views today. I will be happy to answer any questions.

BEFORE THE
INTERSTATE COMMERCE COMMISSION

EX PARTE NO.________

PETITION FOR INVESTIGATORY RULEMAKING MOTOR CARRIER INSURANCE RATES

AMERICAN TRUCKING ASSOCIATIONS, INC.

By: WILLIAM S. BUSKER
Vice President,
Legal Affairs
LANA BATTS
Vice President,
Policy
KENNETH E. SIEGEL
Associate General Counsel

American Trucking
Associations, Inc.
2200 Mill Road
Alexandria, Virginia 22314
(703) 838-1857

Dated: August 21, 1985

BEFORE THE
INTERSTATE COMMERCE COMMISSION

PETITION FOR INVESTIGATORY RULEMAKING MOTOR CARRIER INSURANCE RATES

COMES NOW the American Trucking Associations, Inc. (ATA), pursuant to 49 U.S.C. §10321 and 11701, and 49 C.F.R. Parts 1110 and 1117, and hereby petitions the Commission to institute an investigatory rulemaking into the cause and effects of the current increases in insurance premium rates for motor carriers leading to the adoption of findings and/or rules which will assist motor carriers in acquiring and maintaining the required insurance and in controlling the increased costs.

Identification and Interest of American Trucking Associations, Inc.

The American Trucking Associations, Inc. is a national trade association which represents the interest of the trucking industry throughout the United States. It is a federation whose membership is the individual motor carriers and affiliated trucking associations in each of the fifty states and the District of Columbia. The association participates regularly in proceedings before the Commission, other state and federal agencies, and in state and federal courts representing the interests of the motor carrier industry.

ATA is joined in this petition by the American Movers Conference; Film, Air and Package Carriers Conference, Inc.; Interstate Carriers Conference; Munition Carriers Conference, Inc.; National Automobile Transporters Association; Private Carrier Conference; Regional and Distribution Carriers Conference; Regular Common Carrier Conference; and Specialized Carriers and Rigging Association.

Statement

The Congressional goal of the Motor Carrier Act of 1980 toward maintaining a safe, efficient, economically sound and competitive, privately owned motor carrier transportation system, 49 U.S.C. 10101, is being hampered by the current "hard market" in the insurance industry. Motor carriers are faced with the obstacles of staggering increases in their insurance premium rates, withdrawal of many insurance carriers from the motor carrier insurance market, and severe limitations on the number of policies that insurance companies staying in the market can or will write. Motor carriers are not only finding the Congressionally required insurance more expensive but more difficult, or even impossible, to obtain.

Pursuant to the provisions of section 10927 of Title 49, United States Code, 49 U.S.C. 10927, the Commission cannot issue an operating certificate, permit, or certificate of registration to a motor carrier until that carrier has submitted evidence of a bond, insurance policy, or other type of security, approved by the Commission, in an amount sufficient to cover all environmental, personal liability, or loss or damage of property judgments against the carrier. Further, a carrier's certificate, permit, or registration remains in effect only as long as the carrier maintains the required insurance. 49 U.S.C. §10927.

The current insurance market makes it difficult for new and existing carriers to obtain the insurance necessary to comply with this requirement. Further, those carriers who are able to obtain insurance are often faced with serious delays in acquiring the coverage required, and when insurance is available it is at a highly inflated rate. The amount of a motor carrier's insurance rate increase bears no apparent relationship to the individual carrier's or the motor carrier industry's claims ratio or claims history. A carrier's rate increase appears to be a function of the financial needs of the individual underwriter(s) rather than the claims record of the carrier. Increases of 300% to 400% are more and more common throughout the motor carrier industry. Increases of 500% or more are not unheard of.

The Commission is well aware of the existence of these problems. The crisis facing the motor carrier industry has been demonstrated by the number of carriers who have sought individual permission to adopt insurance surcharges and the great increase in the number of carriers the Commission's enforcement arm has discovered which have been forced by the current crisis to attempt to operate without insurance. The number of such enforcement actions brought by the agency this year, compared to the number brought in prior years, has increased dramatically.

To offer some help to the industry, ATA has recently instituted an "insurance hot line" intended to answer carriers' insurance-related questions and to guide carriers to sources of available insurance. The "hot line" has been receiving 35-50 calls a day. It is clear that insurance availability and insurance rate increases are one of the major problems facing the motor carrier industry today.

Focus of the Investigatory Rulemaking

For the above stated reasons, ATA requests that the Commission initiate a two-stage investigatory-rulemaking. In the first part of the proceeding, the Commission should seek public comment as to the depth and cause of the insurance crisis in the motor carrier industry; the relationship, if any, between the premium rates charged carriers and the carriers' claims ratios, etc.; the availability of insurance and the prevailing rates for insurance in the industry. The agency should also examine how many carriers have been forced to cease or curtail operations as a result of their inability to obtain insurance coverage or obtain it at a reasonable rate. The Commission should also investigate the effectiveness of insurance surcharges in easing the financial burden on individual companies and determine the feasibility of adopting a general insurance surcharge for the motor carrier industry and determine what other relief is available or required to alleviate the current crisis.

The agency should obtain responses from members of the insurance industry, using its general subpoena powers, 49 U.S.C. §10321, to obtain the information needed to study this problem.

After conducting the first phase of the proceeding, the ICC should release their Finding of Facts and Recommendations and promptly, in accordance to the findings made, institute the appropriate rulemakings or policy proceedings and submit recommendations to the Congress for legislative action.

WHEREFORE, the American Trucking Associations, Inc. respectfully requests this Commission to initiate an investigatory rulemaking into the causes, effects and possible remedies of the insurance crisis now facing the motor carrier industry.

Respectfully submitted,

AMERICAN TRUCKING ASSOCIATIONS, INC.

WILLIAM S. BUSKER
Vice President,
Legal Affairs
LANA BATTS
Vice President,
Policy
KENNETH E. SIEGEL
Associate General Counsel

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Alexandria, Virginia 22314
(703) 838-1857

Chairman PICKLE. I thank you, Ms. Batts.

We will go to the other members before questions.

Mr. John Parish, representing the Sporting Goods Manufacturers Association.

STATEMENT OF JOHN PARISH, PRESIDENT, LANNOM MANUFACTURING CO., INC., ON BEHALF OF THE SPORTING GOODS MANUFACTURERS ASSOCIATION

Mr. PARISH. Thank you, Mr. Chairman.

We appreciate the opportunity accorded the Sporting Goods Manufacturers Association to testify here today.

I would like to ask the committee to include written statements from a number of sporting goods manufacturers if I may.

Chairman PICKLE. Which companies would that be?

Mr. PARISH. They will be a number of companies, sir.

Chairman PICKLE. How many are there?

Mr. PARISH. There are about six or eight.

Chairman PICKLE. We will include them in the record.

Mr. PARISH. If that creates a burden, that is all right, I think our testimony will state the case for all.

As a background, I am president of Lannom Manufacturing Co., located in Tullahoma, TN, a baseball equipment operation. I serve as chairman of the Sporting Goods Manufacturers Association Government Relations Committee. Our association represents 3,900 equipment, footwear, and clothing sporting goods manufacturers.

The product liability and liability insurance crisis is really putting American sport out of business. Over the last 5 years, for example, my own company which has not experienced any claims against it, yet our insurance premiums have increased dramatically. In 1984–1985, $17,000; this year it will exceed $159,000 for basic coverage with the total with our umbrella to go to over $250,000.

I only say that to give you an example of what is happening throughout the sporting goods industry.

Our liability insurance experience as I say is not an isolated case in the industry. Submitted today are the statements from these other sporting goods manufacturing companies who have had more horrifying experiences and those facing the greatest hardship are smaller, family-owned businesses.

For example, Adams Plastics in my home State, a family business, had to destroy its remaining face guards in the inventory in 1977. Liability insurance coverages for this company was denied in 1977 through 1981. In 1981 they paid a $4,000 premium for $2 million umbrella coverage, in 1984 it increased to some $12,000 for $5 million worth of coverage, and today it is paying $187,000 for only $1 million of coverage.

This is a company which never had a claim or award settled against it directly in all its years of business, and they are insured with the only carrier in 1985 to quote a rate.

While the insurance companies purport that pricing liability insurance coverage is made on a case-by-case basis, it appears classification of risk and pricing go hand in hand. The sporting goods industry has been tagged as an industry that has too much product exposure, and is too high a risk to insure.

The product insurance liability problems of the sporting goods industry are not relegated simply to baseball and football. Exercise equipment companies, ski, camping, hunting, diving; those that produce soccer balls, lacrosse equipment, hockey equipment, golf equipment are all subject to the unreasonableness of the legal and insurance environment which could result in a demolition of the sporting goods industry.

The economic impact of this is felt not only by manufacturers but retailers, schools, youth sports leagues and athletes. If reform of our product liability laws does not take place, the American economy and people stand to lose much more than just fun and games. Let me lay a headline on you I just learned about last week, the U.S. Olympic Committee and its governing bodies may not have insurance after April 30.

The only way they would be able to get basic liability coverage would be to self-insure using the $4 million earned from the Los Angeles Olympics that was to be put into supporting and promoting amateur programs and athlete development.

The liability problem in this country has a potential to kill amateur youth sports. I have cited examples in my testimony, the Amateur Softball Association, Soccer League, and so forth.

It is a real problem for these associations which do so much to promote youth sports in this country, and without them youth sports won't exist.

There is a distinct probability—this is a very key important point—possibility that volunteers which are the very heart of amateur sports will refuse to donate their services if continually and unexpectedly exposed to frivolous liability litigation. I give an example and this is just quickly on one Little League player who was hit by a fly ball in New Jersey. The parents sued for $750,000, finally settled for $25,000. They sued on the basis that the volunteer coach didn't recognize the player was a natural infielder instead of outfielder.

I could go on with horror stories and we all read about them in the paper every day, so I won't go into them.

The other issue is that many schools are faced with dropping their interscholastic sports program because of the unavailability of insurance.

To come full circle on the impact of the present products/insurance problem on the sporting goods industry, we cannot forget the situations that our cities and towns are facing in attempting to ensure their park and recreation programs. The majority were having a difficult time finding any liability insurance and the concessionaires who deliver recreational services on our national parklands and waters are finding themselves in a similar situation. In fact, I serve on the Tennesseans Outdoors Recreation Commission and we hear from the Smokey Mountain National Park where they cannot get concessionaires for horseback riding.

The old white water rafting is in serious question because the outfitters cannot get coverage or the coverage is too expensive.

But in conclusion, Mr. Chairman, I would like to make two other points if they would interest the committee in its jurisdiction over trade matters. Before me is a ball, this ball is labeled RIF. "RIF" stands for reduced injury factor.

I use this as an example and it is a personal example because it is something that we thought as a company we would be making contributing to sports safety.

Against the advice of our insurance carrier we introduced this new technology for baseball safety. Our carrier felt this new ball would imply that our traditional, conventional balls were not safe.

I won't go into the statistics, but Wayne State University verified that with a kid getting hit with a ball going 79 miles an hour, the injury potential would be reduced by some 70 percent. There are many companies, however, that because of liability exposure and unaffordable insurance, can no longer introduce new products that will target them if an injury happens to occur.

Foreign manufacturers are gaining in the U.S. market because of the price of product liability insurance and litigation that makes us uncompetitive.

A tremendous amount of time is being chewed up by an inefficient tort system that could be channeled into productive product development, sports safety programs, and a more competitive U.S. industry. Perhaps we should all stay home and play checkers.

Yet, if the product liability and liability insurance situation is not acted on by Members of Congress, we will have literally sued the United States out of the sporting goods industry and very quickly as a last comment, what we are suggesting and feel is that Congress should enact Federal uniform tort liability reform. We feel this is a must.

Judges and juries need clear guidelines and rules that bring about reasonableness and some of the things that the lady that preceded me presented, we concur with. So I will not reiterate those.

Thank you very much, sir, for this opportunity.

[The prepared statement follows:]

Statement of John Parish
President, Lannom Manufacturing Co.
on behalf of the
Sporting Goods Manufacturers Association

Mr. Chairman. Thank you for providing an opportunity for the Sporting Goods Manufacturers Association to testify today on the liability insurance crisis. As background, I am the President of Lannom Manufacturing, located in Tullahoma, Tennessee, a baseball equipment operation. I also serve as the Chairman of the SGMA Government Relations Committee; I am a member of the Commission for Tennessean's Outdoors; and I am also Chairman of the Tennessee Governor's Task Force on Day Care.

As providers and producers of sports and recreation in the United States, the entire sporting goods industry and sports community is in trouble. The products liability and liability insurance crisis is putting American sport out of business. Over the last five years, my own company has not experienced any claims against it; yet our insurance premiums have increased dramatically. In 1984-85, we paid $14,300 for $500,000 worth of coverage; we had a $5 million umbrella for $2,800. Total premium for 1984-85 amounted then to $17,100. In 1985-86, we paid $70,000 premium for $500,000 worth of coverage; for $7 million worth of execess, we were charged $50,000. For 1986-87, we have been quoted a premium of $159,000 for $500,000 base coverage, and no umbrella. This quote is the most reasonable received from five companies that stated they would provide us with a bid. 25 companies refused to quote us. For the $120,000 that we are paying this year, we were only able to obtain that insurance the day our policy expired.

Our liability insurance experience is not an isolated case in the sporting goods industry. Submitted today are statements from other sporting goods companies who have had more horrifying experiences, and those facing the greatest hardship are smaller, family-owned businesses. While the liability insurance crisis is a very popular term in 1986, it has been a nightmare to the sporting goods industry for years. An example of the reality that members of the sporting goods industry have had to face is revealed in the story of Adams Plastics.

Adams Plastics, a family business in Tennessee, had to destroy all of its remaining faceguards in inventory in early 1977, because of a lack of liability insurance being made available to them. Liability insurance coverages for this company were denied 1977 through 1981. After the company convinced its insurers that they were out of the faceguard business, the insurance carrier agreed to write coverage. In 1981, they paid a $4,000 premium for a $2 million umbrella; in 1980, it increased to $12,000 for $5 million worth of coverage; and today it is paying $187,000 for coverage of $1 million. This is a company which never had a claim or award settlement against it directly in all its years of business. And their insurer was the only carrier in 1985 to quote a rate.

While the insurance companies purport that pricing of liability insurance coverage is made on a case-to-case basis, it appears that classification of risk and pricing go hand in hand. The sporting goods industry has been tagged as an industry that has too much product exposure and is too high a risk to insure.

The products/insurance liability problems of the sporting goods industry are not relegated simply to baseball and football. Exercise equipment companies, ski companies, camping, hunting, diving companies; those that produce soccer balls, lacrosse equipment, hockey equipment and golf equipment, all are subject to the unreasonableness of the legal and insurance environment, which may result in the demise of the sporting goods industry.

The economic impact of this crisis is felt by manufacturers, retailers, schools, youth sports leagues and athletes. If reform of our country's products liability laws does not take place, the American economy and the American people stand to lose much more than fun and games.

Let me lay a headline on you today that shows the breadth of this problem. The U.S. Olympic Committee and its governing bodies may not have insurance after April 31st. The only way that they would be able to get basic liability coverage would be to self-insure, using the $4 million earned from the L.A. Olympics that was to be put into amateur sports programs and athlete development.

The liability problem in this country has the potential to kill amateur youth sports. A few examples in point:

- The Amateur Softball Association, composed of 182,000 teams and 3.5 million participants in 1985, has seen its liability premium go from $7,000 in 1985 to $150,000 this year.
- The Soccer Association for Youth Organization, which oversees 4,600 youth soccer teams in 12 States is seeing the very fabric of its program threatened. In 1984, they had a $1 million general liability policy for everyone in the program, at a cost to the organization of $4,500 per year. In 1985, that same exact insurance coverage cost $22,500, or a 493 percent increase.

> They anticipate at least $45-50,000 premium for these same coverages in 1986. They have already increased their membership dues 25 percent in each of the past two years, and do not believe that member soccer clubs can continue to pay higher costs.

The crisis for youth sports continues in another area. There is a distinct possibility that the volunteers, the heart of amateur sports, will refuse to donate their services, if continually and unexpectedly exposed to frivolous liability litigation. In Runnemede, New Jersey, a Little League player was hit in the eye by a fly ball that was lost in the sun. The parents sued the team manager and three coaches for $750,000, and settled for $25,000. They were sued for failure to recognize that the player was a natural infielder, and not an outfielder. During a girls softball game a fight ensued between two players. The city, its recreation department, and the association and its manager were sued $3 million. While the suit was dropped, the city's cost and availability of insurance increased dramatically, apart from the legal costs that they were faced with paying.

The horror stories of absurd suits, extravagant awards and dramatic insurance premium hikes can go on and on. But they not only affect the manufacturer and the amateur youth sport organization, they also affect our nation's schools. After losing a $1.6 million judgment for a pole vaulter who missed the mat, and another judgment in excess of $1 million, an insurance company cancelled the policies of 585 schools.

This is not an extreme example of an injury award in the sports area; and many schools are faced with dropping their interscholastic sports programs because of the unavailability of insurance. We know this is especially the case in California, which is an extremely litigious State. The school market is an institutional market that the sporting goods industry cannot afford to lose. In addition, America cannot afford to lose the benefits that interscholastic sports have provided to the American education process and to youth throughout this country.

To come full circle on the impact of the present products/insurance liability problem upon the sporting goods industry, we cannot forget the situations that our cities and towns are facing in trying to insure their park and recreation areas. The majority are having a most difficult time finding any type of liability insurance. And the concessionnaires, who deliver recreational services on our national parklands and waters are finding themselves in a similar situation. The U.S. National Park Service is presently reviewing all of its contracts with concessionnaires. White water canoeing, rafting and horseback riding may no longer be available to those who want to enjoy the beauty of our recreation estate. Needless to say, the suspension of these operations will cause the bankruptcy of thousands of small businesses.

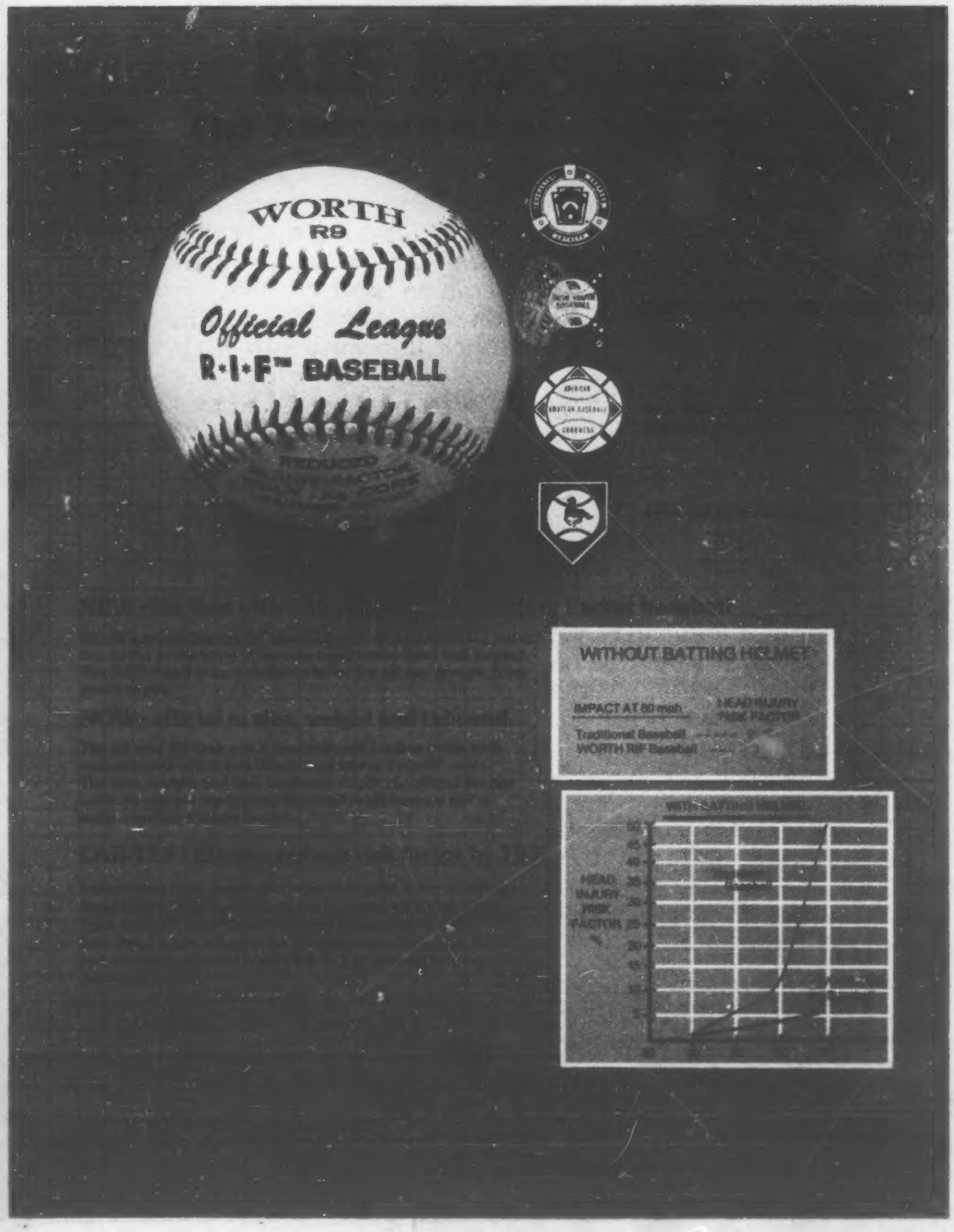
In conclusion, Mr. Chairman, I would like to make two other points, as they would interest the Committee in its jurisdiction over trade matters. Before me is a ball that we have labeled the "RIF Ball"; RIF stands for the words "Reduced Injury Factor".

Against the advice of our insurance carrier, we introduced this new technology to promote baseball safety. This ball has been lab tested by Wayne State University as reducing the injury risk factor of a ball speeding 70 to 90 miles per hour by 70 percent. The head injury risk factor with a traditional baseball is 99 percent with a ball being pitched at 60 miles per hour. The RIF Ball reduces that head injury risk factor to 1 percent. What we recognized as a company, in introducing this ball into the marketplace, was that in order to remain competitive with our foreign counterparts, we had to be willing to introduce new technology. Correspondingly, we are responsible for producing instruments of action that not only provide tens of millions of Americans with recreational enjoyment, but also with the opportunity to participate in sports utilizing product that will maximize their safety, even though we will never be able to eliminate all risks in sport. The nature of the activity is competitive, aggressive and action-oriented.

There are many companies, however, that because of liability exposure, and unaffordable insurance coverage, can no longer introduce new product that will target them if an injury happens to occur. A company that was the pioneer of hockey protective equipment -- helmets, shinguards, goalie guards and chest protectors -- no longer produces these lines. The only available protective product in the sport is produced by the Canadians, the Swedes and the Czechs. Therefore, it is in line to make the correlation that the present products liability and liability insurance situation presents a competitive disadvantage to U.S. manufacturers. For our industry, a U.S. manufacturer's products liability costs represent on average 4.2 percent of sales, while the foreign producer's costs are approximately one-half of one percent.

Foreign manufacturers are gaining in the U.S. market because the price of product liability insurance and litigation makes us uncompetitive. Consumers that are injured using foreign product also may not be able to reach the foreign producer, and therefore may not be able to be compensated for legitimate injury. The consumer is impacted in other ways: 1) Less product is available; 2) U.S. jobs are lost or never created; 3) If the product is foreign produced, with the importer/retailer having a certificate of insurance from the foreign company, we hope that a) the foreign company is carrying a suitable amount of insurance for typical catastrophic injury awards in the U.S., b) that the foreign company will be in business when an injured person files a claim or lawsuit, and c) the foreign company doesn't refuse to deal with the situation.

A tremendous amount of money is being chewed up by an inefficient tort system, that could be channeled into product development, sport safety programs, and a more competitive U.S. industry. Perhaps we should all stay home and play checkers. If the products liability and liability insurance situation is not acted upon by Members of Congress who have the power and authority from the American people to fix this devastating situation, we will have literally sued the United States of America out of business. Thank you. I am willing to answer any questions that the Committee may have.


WORTH
R9
Official League
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Traditional Baseball

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NOW - official in size, weight and rebound.

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Chairman **Pickle**. Thank you, Mr. Parish.

What is that RIF ball made of?

Mr. **Parish**. Polyurethane foam core, looks like and feels like and plays like a conventional baseball but when it hits it absorbs the impact.

Chairman **Pickle**. The regular baseball is made of what, twine?

Mr. **Parish**. Yes, sir.

Chairman **Pickle**. Wrapped round and round, and this is a foam?

Mr. **Parish**. Molded polyurethane foam core and it has all the properties of a conventional baseball which as you correctly stated, is a wool yarn wound ball that remains hard.

But when the RIF ball comes under heavy impact, this one gives, it feels hard to the touch but once it comes into high impact, it gives.

Chairman **Pickle**. What would a regular bat do to that?

Mr. **Parish**. The performance is the same.

Chairman **Pickle**. You mean it won't go further out of the ball park?

Mr. **Parish**. No; its performance characteristics are exactly the same. It has a little different sound, but is otherwise very similar. It in every respect looks like, feels like and plays like the real thing.

Chairman **Pickle**. Are you going to leave that with us?

Mr. **Parish**. I would be happy to do so.

Chairman **Pickle**. Maybe you could give each one of us a moment to inspect that.

Mr. **Parish**. I will do that.

Chairman **Pickle**. Now, Mr. Humphreys.

STATEMENT OF DAVID J. HUMPHREYS, CHAIRMAN, AMERICAN RECREATION COALITION, AND PRESIDENT, RECREATION VEHICLE INDUSTRY ASSOCIATION, ACCOMPANIED BY ROY MUTH, PRESIDENT, INTERNATIONAL SNOWMOBILE INDUSTRY ASSOCIATION

Mr. **Humphreys**. Thank you, Mr. Chairman, and thank you for this opportunity to explain the trauma being felt throughout the recreation community today because of the liability crisis.

I serve as chairman of the American Recreation Coalition, a broad federation of more than 100 associations and corporations active in recreation. Our membership ranges from well-known companies such as Coleman, Disney, and KOA to recreation industry associations to enthusiast groups such as the Good Sam Club, American Youth Hostels, and the National Campers and Hikers Association. A complete listing of ARC members is attached.

The liability crisis is affecting every element of the $250 billion per annum recreation industry and, increasingly, the recreation choices open to each of us. The problems created for small businesses in the recreation field—campgrounds and marina operators, white water rafting outfitters and pool companies—are immense and growing. These companies are the backbone of the recreation industry, key to our Nation's response to America's changing and growing appetite for quality recreation opportunities.

As a nation, we must come to grips with the trend toward excessive litigation and claims for compensation, regardless of actual fault. Balance must be restored to our civil justice system. In the recreation field, we are especially in jeopardy in the courts today because risk is an integral part of so many recreational activities, from skiing to flying, rock climbing to horse riding. Again and again, the Nation's courts have elected to ignore the conscious choice of individuals to expose themselves to these risks and to provide compensation for injuries at the expense of conscientious recreation providers and equipment manufacturers.

With me today is Roy Muth, president of the International Snowmobile Industry Association and chairman of the American Recreation Coalition's task force on liability concerns. Through Roy's task force, we have developed a white paper documenting the seriousness and breadth of the crisis recreation is facing in attempts to obtain affordable liability insurance coverage. Copies of this report have been provided to your staff and further information on the instances cited in the paper can be provided. We ask that the report be made a part of your hearing record.

Finally, I ask that Roy Muth be permitted to briefly tell you about several very disturbing examples contained in the report.

Mr. MUTH. Thank you, Mr. Chairman, I would like to outline some of the situations now confronting recreation in the liability insurance field.

We find that manufacturers are facing spiraling costs and diminishing coverage, for example, a snowmobile manufacturer had a tenfold increase in its insurance premium and its deductible during the past year—despite the absence of any claims. In addition, the average premium increase for companies in the boating field over the past year has been 380 percent, and a significant number of companies are unable to obtain coverage at any price.

Consumers are facing immense price escalations for some products. For example, 30 percent of the cost of a new kit-built biplane represents the cost of liability insurance.

A tremendous pressure against the adoption of voluntary safety standards in the recreation field is being felt. The National Spa and Pool Institute, for example, has an active standards program designed to reduce product-related injuries. The result: from 1984 to 1986 its insurance coverage was reduced 90 percent, its deductible was increased by 2,900 percent, and its premium was increased by 565 percent

Many recreation services are being abandoned. For example, many horse liveries simply cannot get insurance. In Maryland, this has meant the cancellation of a therapeutic riding program for handicapped children.

On Federal lands, private providers of services at campgrounds and marinas, on rivers and at winter sports sites are faced with being put out of business as they are caught between Federal regulations requiring them to carry liability insurance, and an absence of companies who will write the policies.

Providing transportation for groups of tourists is becoming more difficult. For example, a 4-year-old, growing sightseeing bus company in Nevada was forced to sell two of its seven vehicles to cut its insurance costs, even though this reduction will force it to turn down revenues and threatens is economic viability.

A crisis has erupted for nonprofits that sponsor competitive events. The American Water Ski Association, for example, cannot get coverage to protect volunteers who stage events.

Major jumps in insurance premiums for recreation shows will force sponsors to increase entrance costs for RV, boat, and ski shows.

Mr. Chairman, the chaos we see today in the recreation community produced by the insurance crisis must not continue. Manufacturers face choices between accepting uncontrollable costs, abandoning product lines, or even closing down. Product improvements and voluntary standards development are discouraged. Organizations providing recreation services and facilities are even more constrained.

The threat of economic ruin is real for them whether they try to cover escalating costs without driving away their customers, try to operate without insurance in the present litigious climate, or simply decide to close down because they are no longer profitable.

In addition, these providers of both goods and services find that their safety records and claims history have little or no bearing on their ultimate insurance situation. Consumers, in turn, are left with increasing recreation costs and diminishing recreation choices. There are no winners and losers here—only losers.

This stark conclusion underlies the need for action at both the Federal and State levels to reestablish a stable insurance climate in the United States. We ask this body's help in an effort to find appropriate solutions.

[The report and list of members of ARC follows:]

The Impact of the Insurance Crisis on the Recreation Community

ABSTRACT

The insurance crisis in the United States threatens widespread curtailment of recreation opportunities for millions of Americans. As jobs in the myriad small businesses which make up the recreation industry disappear, countless communities nationwide will be deprived of the economic well-being that accompanies the natural partnership of recreation and tourism. Lack of adequate insurance at affordable rates inhibits product manufacturers, restrains service and facility providers and deprives recreationists. Manufacturers face a whole new set of uncertainties which impair financial planning, product improvement and standards-development processes. Service and facility providers, ofttimes with mandated government insurance requirements, find that coverage cannot be obtained at any price. Recreationists, whether competitors, enthusiasts or simply spectators, are left with increasing costs and diminishing choices. Remedies are needed at both the state and federal levels to reestablish a stable insurance climate for the recreation community.

The Impact of the Insurance Crisis on the Recreation Community

INTRODUCTION

Today, the insurance crisis -- decreasing or disappearing coverage and steeply mounting premiums -- is clearly in the public spotlight. The plight of cities and counties, of professionals like doctors, of businesses like day-care centers, has received a great deal of attention. However, the insurance crisis is so pervasive that, as the public is gradually coming to recognize, every segment of society is adversely affected.

The purpose of this paper is to describe the very significant impact of the insurance crisis on the recreation community -- all those entities involved in providing recreation to the American public, from equipment manufacturers to local concessioners, and the recreationists themselves. As a starting point, the essential role of recreation in society must be emphasized. In today's tumultuous, stress-filled world, recreation gives people the opportunity to refresh their bodies and spirits -- to literally re-create themselves -- and thus to enjoy happier, more productive lives. Recreation's social importance is reflected in turn by its economic importance: nine million jobs, mostly in small businesses, and over $250 billion in goods and services in America alone.

This substantial sector of the American economy is seriously threatened by the current insurance crisis. The situation is so critical that, unless steps are taken now to address the problem, the widespread curtailment of recreation opportunities for millions of Americans will become a most unpleasant reality. Not only will

Americans be deprived of enjoyable, healthy -- and essential -- recreation, but as tens of thousands of jobs in the recreation and tourism industry disappear, countless communities will be deprived of the economic well-being that accompanies the natural partnership of recreation and tourism.

It is important to bear in mind, in any discussion of the relationship between recreation and insurance, that many forms of recreation involve some degree of risk. Indeed, for many people, that risk is the consciously chosen essence of the recreational experience, the challenge that heightens the enjoyment of the activity. For these recreationists, totally risk-free recreation can be described as a contradiction in terms. However, today, while the risk of recreational activities captures the insurance industry's attention, the abrogation of a recreationist's personal responsibility for assuming that risk is encouraged in courts across the country. As a result, insurance concerns are beginning to paralyze the recreation community.

IMPACT ON MANUFACTURERS

Increased Costs, Reduced Coverage

To begin with, the problem with liability insurance at the equipment manufacturer level is well worth noting. Vying as they are for the consumer's discretionary dollar, recreation equipment manufacturers must always keep a careful eye on costs. Yet now they are faced with spiraling insurance prices that make rational planning impossible and threaten their very ability to produce a marketable product. As an example, the International Snowmobile Industry Association cites the plight of a snowmobile manufacturer faced with a ten-fold increase in its insurance premium -- and a ten-fold increase in its deductible -- despite the absence of any claims against its products.

The Recreation Vehicle Industry Association points out that motor home manufacturers have experienced increases in product liability rates from 300% to 500% over the last two years. Every RV manufacturer has had trouble getting primary insurance and excess coverage regardless of the industry's generally excellent safety record.

Marine businesses are similarly affected. The National Marine Manufacturers Association (NMMA), which represents the recreational boating industry, reports that its members are currently seeing premium increases as high as 1,000% -- when coverage is available. An NMMA survey just completed by manufacturers producing products as diverse as power boats and bilge pumps shows an average premium increase of 380% above the previous year. Three of the 112 respondents reported being unable to obtain any coverage at all.

Threat to Product Improvements

Yet increasing costs and diminishing coverage are just part of the manufacturer's problem. He must also evaluate the impact on his liability exposure of any possible product improvements he might undertake. Will he be found liable because he did not introduce them sooner? Will future coverage be threatened by his technical advances? A good example of this industry dilemma is the case of an aircraft parts manufacturer described by the Experimental Aircraft Association. This manufacturer decided to abandon a year's worth of marketing and engineering research on a totally new electronic ignition project. The product, which would have significantly improved performance and maintenance expenses on today's piston aircraft engines, was dropped because the manufacturer believed that producing the ignition system would lead to increased product liability exposure in an increasingly hostile litigation climate. Even with these kinds of decisions being made, amateur-built aircraft enthusiasts are paying a steep price. A major kit designer and producer reports that 30% of the price of a new kit-built biplane pays for liability insurance.

Effect on Product Standards

The work of recreation-related trade associations and voluntary-standards-writing bodies has also been threatened by drastic changes which have produced reduced liability coverage, increased deductibles and increased premiums. The experience of the National Spa and Pool Institute (NSPI) provides a telling example. NSPI reports that the annual premium for the association's professional liability insurance went from $1,570 in 1984 to $7,738 in 1985, a 393% increase. At the same time, the policy's $5,000,000 limit of liability dropped to $2,500,000.

However, professional liability insurance changes were only the beginning. NSPI administers a voluntary standards program which has necessitated the association's purchase of specialized insurance to cover claims based upon personal injury. In 1984, the association's specialized insurance policy included a $20,000,000 limit of liability, with a $5,000 deductible, for a premium of $20,000. In 1985, although the policy still provided a $20,000,000 limit of liability, the deductible had increased to $50,000 with a $100,000 cap, and the premium had increased to $86,000.

The situation has worsened. In 1986 only $2,000,000 in liability coverage could be placed, even though $20,000,000 was sought. The current policy has a $150,000 deductible with a $550,000 cap. The premium is an incredible $133,000.

Thus, from 1984 to 1986, NSPI has realized a drop in its specialized insurance limit of liability to 10% of the amount needed, its deductible has increased 2,900% and its premium has increased 565%. Ironically, as this example shows so clearly, the insurance crisis is hampering, rather than helping, an important process which has been developed to enhance product reliability and promote product safety.

Effect on Consumers

Obviously, the impact of the insurance crisis does not end with the manufacturer. Those increased costs are invariably, to one degree or another, passed on to the consumer. At the same time, the consumer is deprived of the benefits of technical innovation and, as manufacturers evaluate the cost of staying in business or the feasiblity of abandoning a product line, he may even be denied access to the variety of recreation products once available.

IMPACT ON RECREATION SERVICES

Increased Costs, Fewer Services

Like the product manufacturer, the provider of recreation-related services is also caught in the insurance crunch. The American Horse Council reports that the small businesses -- rental stables, resorts, dude ranches, packers and guides -- which make horseback riding available to the majority of the American riding public are finding it very difficult to locate affordable liability coverage while newcomers to the business have been unable to locate coverage at any price. Such businesses are particularly vulnerable because of their narrow profit margins. Many stables report no claims for several years but have seen their premiums increased five or six fold. Estimates for premiums as high as $50,000 for $300,000 liability coverage, which used to cost $5,000, have been reported. Specific examples show the unhappy results of these developments. In Maryland, a therapeutic riding program which has aided dozens of mentally and physically handicapped children will not be operating in 1986 because the stable owner cannot find insurance coverage. In another example, the popular Michigan summer resort of Mackinac Island, famous for its prohibition of motor vehicles, may soon lose its horse-drawn carriages because carriage companies are unable to secure liability coverage.

Campground operators across the country are also facing an alarming increase in insurance premiums. The National Campground Owners Association (NCOA) reports that, during the first four months of 1985, the average increase was less than 10%. Then, from May to August, the average increase was 20%, jumping to 70% in the last four months of the year. By the end of 1986, it is expected that the average premium increase will be 100% above levels in late 1984. However, increases are only part of the story; insurance availability is also a serious concern. NCOA estimates that 20% to 25% of campgrounds in America are having difficulty in finding insurance coverage, while 10% cannot find the insurance coverage they need or want. Ironically, hardest hit are those campgrounds that expanded services and facilities to respond more completely to consumers' recreational needs.

Member benefits provided by recreation-related associations are another kind of recreation service. These services, which can be a major reason for an association's existence and a major source of association revenues, are also affected by the insurance crisis. A case in point is the insurance program managed by the Academy of Model Aeronautics (AMA) which provides AMA's 105,000 members with liability protection in the event of property damage or bodily injury caused by a member's model aircraft. Since 1940 AMA's insurance program has proven to be the key to the growth of modeling in the U.S. In an effort to provide the same insurance coverage for its members in 1986 as was provided in 1985, AMA solicited bids from sixteen companies. Fourteen declined to even submit a proposal. Despite its efforts, AMA could obtain only half of the $2,000,000 in coverage it had sought, had to limit the types of models covered, and was forced to pay a $250,000 premium, three times the previous year's level. In addition, it was required to increase its self-insurance fund from $100,000 to $150,000.

Limits on Use of Public and Private Lands

Entrepreneurs providing recreational facilities and services on public lands are also faced with a very imminent problem. Federal land-management agencies will not allow these federal permit holders to operate without evidence of insurance. In addition, in states requiring outfitting or guiding licenses, those licenses are not being issued without evidence of insurance. Yet the National Forest Recreation Association reports that its members that provide facilities and services on public lands simply cannot find insurance. These small businesses, operating facilities like winter sports areas, resorts, marinas, camps, RV parks, and technical climbing schools and providing services like guided hikes, pack trips, snowmobile rentals and guided hunts, cannot afford to miss even one season's revenues. The Conference of National Park Concessioners reports similar experiences among its members. The lack of insurance is devastating to these small businesses and their employees while seriously limiting the public use of public lands.

Limiting public use of private lands takes other forms. The International Snowmobile Council cites the experience of a snowmobiler association which runs Vermont's snowmobile trail program under contract from the state. Despite the absence of any serious accidents involving property damage or casualties on the trail system over a number of years, the association was faced with a 200% increase in its premium -- from $9,000 to $27,000. Only the association's ability to raise money quickly from its members and outside contributors and its willingness to restructure its organization completely kept the trail system open to use this year. However, the availability and cost of insurance remain serious concerns, raising the possibility once again of a closed-down trail system next season.

Transportation Concerns

Even a service as basic to recreation as transportation is adversely impacted by the insurance crisis. As the United Bus Owners of America (UBOA) reports, many of its members have struggled recently to find affordable insurance despite a record of consistently providing profits for their insurance carriers. UBOA's concern that loss history has no relationship to its members' treatment by the insurance industry is echoed throughout the recreation community. Members of the American Bus Association (ABA) have faced dramatic liability insurance premium increases too. One new and smaller bus company, based in Nevada, has been forced to sell two of its seven vehicles to reduce its insurance costs. This in turn has caused a reduction in its sightseeing tours -- a pattern ABA describes as all too typical. These developments threaten the pattern of growing numbers of visitors to our parks and other recreation sites who travel in groups aboard buses.

Competitive and Spectator Events in Jeopardy

Recreationists must deal with another negative: the adverse impact of the insurance crisis on competitive and spectator events. As an example, the American Water Ski Association (AWSA), with 20,000 members, is the sanctioning body for water ski competitions. There are 400 water ski clubs affiliated with AWSA which produce hundreds of tournaments, shows, exhibitions, clinics and other events annually. Tournament activity alone involves thousands of skiers, officials and organizers and pumps millions of dollars into the economy. This activity is based entirely on the work of volunteers.

In spite of the excellent safety record at AWSA-sanctioned events, the fear of legal exposure is already hampering the growth and development of the sport. Government agencies with jurisdiction over the water sites are afraid of being sued and often opt to either deny the necessary permits for the events or require such high liability insurance limits that nonprofit groups can't afford it. Landowners on whose property an event is to take place show the same concerns. The local, state, regional and national volunteer organizing bodies are also realizing that the responsibility waivers they relied on for years do not protect them and that the liability insurance they are being asked to carry is now beyond their reach. When insurance is available, clubs are able to purchase only spectator liability coverage; there is no source for participant liability coverage.

Many associations hold consumer shows that draw hundreds of thousands of spectators annually. One of the largest shows is managed by the Recreation Vehicle Industry Association (RVIA) and each year fills a west coast baseball stadium with motor homes and campers of all sizes. RVIA reports that the cost of its show liability insurance increased 300% in the last year. The Experimental Aircraft Association (EAA), which manages one of the largest conventions in the U.S., reports the same experience. This year's insurance premium for the EAA convention (fly-in) has jumped by over 300%. As a result, over $150,000 more in insurance premiums must be covered by registration fees for less insurance.

CONCLUSION

The uncertainty -- even chaos -- produced by the insurance crisis within the recreation community must not continue. Industry well-being is disintegrating as manufacturers face choices between accepting uncontrollable costs, abandoning product lines, or even closing down. At the same time, product improvement and voluntary standards development are discouraged. Organizations providing recreation services and facilities are even more constrained. The threat of economic ruin is real for them whether they try to cover escalating costs without driving away their customers, try to operate without insurance in the present litigious climate, or simply decide to close down because they're no longer profitable. In addition, these providers of both goods and services find that their safety records and claims history have little or no bearing on their ultimate insurance situation. Consumers in turn are left with increasing recreation costs and diminishing recreation choices. There are no winners and losers here -- only losers.

This stark conclusion underlies the need for action at both the federal and state levels to reestablish a stable insurance climate in the United States. Action at the state level can provide relief through tort reform and passage of statutes covering assumption of risk, outlawing the arbitrary cancellation of insurance, implementing market assistance plans or risk pools designed for the recreation community, and placing caps on attorneys' contingency fees and on plaintiffs' awards. Solutions must be developed at the federal level where priority should be given to legislation which provides uniformity in the field of product liability and which expands the opportunities for group insurance made available through the Product Liability Risk Retention Act of 1981.

There are no easy answers to the insurance crisis, but the threat it poses to our society -- in terms of economic, social and technological losses -- clearly justifies an immediate, concerted effort to find appropriate solutions.

American Recreation Coalition

Dedicated to the protection and enhancement of every citizen's right to pursue health and happiness through leisure-time activities.

SUSTAINING MEMBERS: American Bus Association • American Motorcyclist Association • The Coleman Company, Inc. • Conference of National Park Concessioners • Dometic Sales Corporation • Family Motor Coach Association • Fleetwood Enterprises, Inc. • Good Sam Club • Hehr International Inc. • International Snowmobile Industry Association • Jayco Incorporated • Kampgrounds of America, Inc. • Komfort Industries, Inc. • National Campers and Hikers Association • National Campground Owners Association • National Marine Manufacturers Association • National Outfitter and Livery Alliance • National Spa and Pool Institute • Onan Corporation • Recreation Vehicle Dealers Association • Recreation Vehicle Industry Association • Shurflo • Specialty Vehicle Institute of America • Winnebago Industries.

ROUNDTABLE AND CONTRIBUTING MEMBERS: American Resort and Residential Development Association • American Youth Hostels, Inc. • Camp Coast to Coast • Coachmen Industries, Inc. • Happy Trails Resorts • Huffy Corporation • Marine Retailers Association of America • National Club Association • National Motorsports Committee • National Tour Association • Outdoor Resorts of America, Inc. • Walt Disney World • Warehouse Distributors Association.

GENERAL: Academy of Model Aeronautics • American All-Terrain Vehicle Association • American Association for Leisure and Recreation • American Camping Association • American Fishing Tackle Manufacturers Association • American Forestry Association • American Horse Council • American Hotel and Motel Association • American Power Boat Association • American Recreational Equipment Association • American Water Ski Association • Archery Range and Retailers Organization • Association of Importers/Manufacturers for Muzzleloading • Bicycle Manufacturers Association of America • Boat Owners Association of the United States • Boating Trades Association of Texas • Boating Trades Association of Metropolitan Houston • Champion Fleet Owners Association • Colorado Campground Association • Community Research and Resource Center • Experimental Aircraft Association • Holland Motor Homes • Institute for Career and Leisure Development • International Association of Amusement Parks and Attractions • International Family Recreation Association • International Kart Federation • International Military Recreation Association • International Snowmobile Council • Kampground Owners Association • Leisure Systems, Inc. • Maryland Association of Campgrounds • Michigan Boating Industries Association • Michigan Mobile Home and Recreation Vehicle Institute • Motorcycle Industry Council • National Association of Intercollegiate Athletics • National Boating Association • National Employee Services and Recreation Association • National Forest Recreation Association • National Hot Rod Association • National Marine Association • National Off-Road Bicycle Association • National Outdoor Coalition • National Sporting Goods Association • North American Family Campers • Northern California Marine Association • Pennsylvania Recreation Vehicle and Camping Association • Photographic Society of America • Pony Baseball, Inc. • Recreation Vehicle Club Directors Association • Recreation Vehicle Indiana Council • Resort and Commercial Recreation Association • Roller Skating Rink Operators Association • Southern California Loners on Wheels • Southern California Marine Association • Southern RV • Special Recreation, Inc. • Specialty Equipment Market Association • Sporting Goods Business Magazine • Texas Recreation Vehicle Association • United Bus Owners of America, Inc. • United Four Wheel Drive Associations • United States of America Field Hockey • U.S. Recreational Skiers Association • Wally Byam Caravan Club International • YWCA National Board.

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Mr. PICKLE. Well, thank you, Mr. Muth, and Mr. Humphries, for your testimony.

The next witness will be Mr. Sarasin.

STATEMENT OF RONALD A. SARASIN, DIRECTOR, GOVERNMENT RELATIONS, NATIONAL RESTAURANT ASSOCIATION

Mr. SARASIN. Thank you, Mr. Chairman, for the oppotunity to be here this morning.

Just to give you a little background on the National Restaurant Association with whom I am the director of government relations. We are the leading food service organization in the country. Food service represents 5 percent of the gross national product. We are a $178 billion business employing 8 million people. Of our 10,000 members of this industry, we represent about 100,000 food service outlets. Now liquor liability, Mr. Chairman, is a very, very serious problem to those of us in the restaurant industry. Next to pollution insurance, it is probably the most difficult type of insurance to obtain.

We have been able to document from our members over the last few years startling increases in the cost of and lack of availability of insurance. A Michigan operator reported to me and also to the other body that his liquor liability policy increased 760 percent, and umbrella coverage which took effect when he reached $1 million increased 2,600 percent.

We asked the Gallup Survey people to do a survey for us, and 69 percent of the people surveyed reported increases with an average of 110 percent, the average premium for liquor liability insurance is $39,500, and 91 percent of the people surveyed never had a claim.

Now, our situation is slightly different than many of those organizations and groups that have come before you because we are really not the actor in the lawsuit. We are a third party.

The actions we face are just that, third party liability suits. We are not the actual cause of the damage. There is usually a driver involved but we are held liable anyway. We don't believe we are responsible for the actions of our patrons, but we try to take, with regard to those patrons, very responsible actions. As an aside, the National Restaurant Association has created a three part alcohol awareness program because we are concerned about people driving under the influence of liquor.

Part of that program, the first part, involves consumer education to point out to the public and patrons generally that there are dangers in driving under the influence. Two, we are heavily involved in server training, getting our people to be able to identify someone who has perhaps had too much to drink.

Three, we are recommending a number of changes in in-house practices, so we provide more food, discourage overconsumption, and discourage putting more than one drink before a person at any time.

We believe we are taking responsible actions with regard to drunk driving.

But the situation that affects us as third parties goes beyond that. We are not alone here. It is just not the restaurateur suffering from this problem. We have seen a number of States and number of courts that extended the liability to the individual in his own home. So we are seeing host liability at the same time.

As a result, in one of the surveys, an AP poll, 72 percent of the people surveyed said they not only didn't feel the host should be responsible, but they didn't feel the bartender should be responsible for the activities of the intervening cause, that is someone who goes out and causes an automobile accident.

The situation we face now and that many people in this country will face, is if somebody has too much to drink at your daughter's wedding, you could find yourself sued on a third party basis and could possibly be hit with some rather horrendous damages.

The restaurateur becomes the victim of a victim. In some cases, we have seen the scattergun approach occurring where plaintiff's attorney will sue everybody in sight, including every restaurant and liquor outlet in an area, not knowing who if anyone may be responsible.

As a practical matter, the restaurant industry serves only 25 percent or a little less than 25 percent of all the alcohol consumed in this country.

Now, we did make suggestions for changes. One would be to establish dollar caps to try and provide a mechanism for reasonableness in the awards that have been provided. I did listen to Attorney General Bell and I would accept his recommendation that punitive damages be paid to the court because he is right, they are in the nature of a fine and if you are trying to teach a defendant a lesson, you shouldn't teach him a lesson over and over and over again, with every individual plaintiff who may come before the court.

Joint and several liability must be changed. Joint and several liability, as the Department of Justice group pointed out, was originally based when there was a conspiracy involved. Now we have seen it used in an effort to get to the deepest pocket. In many cases in our area, the deep pocket is the restaurateur.

Advance notice in liquor liability cases would be extremely effective. It is very difficult, 2 years later, just before the statute runs, to try and reconstruct what happened on that occasion. Your people are gone, they are no longer working in the industry, you haven't the slightest idea whether that individual was ever in your restaurant and you are going to find yourself perhaps at the wrong end of a lawsuit.

Reasonable statutes of limitations are necessary for the same reasons.

It has become a lottery for the plaintiff, Mr. Chairman, and in many of the third party product and service liability suits that we have seen, fault doesn't matter to the trier of fact, the belief is that the insurance company will cover it.

I don't come to this subject cold. In 1976, as a Member of this body, I introduced the first product liability bill in the Congress, and I would suggest that the problem has dramatically and geometrically increased in the 10-year period. Frankly, at that time I hadn't thought much about service liability which is something that greatly affects us in the restaurant industry today.

We all pay, Mr. Chairman, for a system that has gone haywire. Consumers pay for it, and society pays for it in general. It has got to be changed.

I thank you for the opportunity to be here this morning.

[The prepared statement follows:]

STATEMENT OF RONALD A. SARASIN, DIRECTOR, GOVERNMENT RELATIONS, NATIONAL RESTAURANT ASSOCIATION

Mr. Chairman, thank you for the opportunity to appear before the subcommittee to testify about the severe difficulty. Crisis if you will, that the foodservice industry is facing in obtaining affordable liquor liability insurance.

My name is Ronald A. Sarasin, director of government relations for the National Restaurant Association (NRA). NRA is the leading trade association for the foodservice industry. Foodservice industry sales currently represent 5 percent of GNP, with 1985 sales totaling $178 billion. NRA's 10,000 members represent more than 100,000 foodservice outlets, who are engaged in a variety of businesses associated with the consumption of food away from home.

Like other industries, restaurateurs are experiencing enormous increases in the cost of liability insurance. Liquor liability insurance is the most difficult coverage to obtain after pollution risk. In some regions of the country, it is simply not available. Where it can be obtained, rates have skyrocketed.

For the past few years, NRA members have been reporting these increases. One operator in Washington, D.C. saw his premium climb from $185 to $26,500 in one year. A Michigan operator reported an increase from $6,700 to $30,520. A restaurateur in New Jersey reported that the cost of his total liability package rose from $25,000 to $92,000.

To get a better perspective on this situation, NRA engaged the Gallup organization to survey our industry and develop some average figures. The results are astounding. Sixty nine percent of the respondents reported increases in liquor liability premiums during the previous year, although 91 percent said they had never been named in a suit. The average increase was 110 percent; the average premium paid, $39,500.

The search for the causes of these startling increases takes us back through conditions within the insurance industry to the growing number of liquor liability suits brought against foodservice operations. The International Risk Management Institute estimates that there has been a 300 percent increase in such suits during the past year. There has also been an equally alarming increase in the size of the out-of-court settlements and jury awards that result from these suits.

Let me read you a short list of recent liquor liability awards:

$1.7 million settlement against a convenience store in Florida.

$3.9 million settlement against a Chinese restaurant in Massachusetts.

$4.3 million verdict against a bar in Minnesota.

$8.7 million verdict against a resort hotel in Pennsylvania.

$10 million verdict against a dinner club in Alabama.

These figures have been verified, but I first discovered them in a brochure promoting an American Bar Association seminar to assist lawyers in handling liquor liability cases.

The situation I have described so far parallels the circumstances faced by other industries. What makes our situation slightly different is that the court actions we face are third party liability suits. That is, the restaurateur is not the actual cause of the damage, but he or she is held liable anyway. Today, eighteen States have dram shop laws which hold the server of alcoholic beverages accountable for actions of the consumer. Seventeen States establish the same liability through common law precedent. And five States have both dram shop laws and common law liability.

There has been considerable public dispute as to whether a server should be held liable for the actions of the consumer. That is a question our society needs to address. Most restaurateurs will tell you that they are not responsible for the actions of a patron, but they have taken responsible actions anyway. Let me focus on that distiction for a minute.

Two years ago the National Restaurant Association introduced a three-part Alcohol Awareness Program. The first part of this program involves consumer education. We committed ourselves to working with other public interest groups to warn the Americans about the dangers of drunk driving.

The second part of this program involves server training. We prepared a seminar for servers of alcoholic beverages. It covers questions such as how to recognize a guest who is becoming intoxicated, how to cut-off service to such a guest and how to keep an intoxicated patron from driving. This seminar has now been offered in 37 States, and we are now revitalizing it and realising it in a new form in the near future.

The third part of this program involved recommendations on in-house practices. NRA advised its members to eliminate all multiple-drink promotions which might be perceived as fostering over consumption. We advised them to introduce bar food, designated driver programs and alternative transportation programs.

The great majority of restaurateurs across this country have adopted our program. That is, they are taking responsible action in regard to drunk driving. But that does not mean that they are assuming responsibility for the actions of a patron who does become drunk despite their efforts.

Recently, the question of third party liability has become more heated because of the proliferation of cases involving social host liability. In eighteen States, a host or hostess can now be held liable for the actions of an intoxicated guest. This new extension of liability has quite literally brought the plight of the bartender home to the average citizen. As a matter of fact, a recent AP poll showed that 72 percent of respondents believe that bartenders should not be held legally responsible for injuries caused by intoxicated patrons.

It is not my purpose to argue the case against third party liability. I merely wish to point out that our society is by no means unanimous in holding one citizen responsible for the actions of another. Nevertheless, the number of third party liability cases is escalating rapidly and awards ranging up into the millions are being regularly handed down.

Imagine for a moment the parties in court when such a case is tried. First there is the plaintiff. He or she may be the actual victim of an automobile accident, and may be maimed, scarred, or crippled. With the coaching of a good attorney, the plaintiff will describe both the agony suffered and the long term effects of the accident.

Or the plaintiff may be a spouse, parent or child of a person killed in the accident. In this case, the plaintiff will testify to the loss of love and financial support, and to the anguish and grief suffered.

In either case, the plaintiff has and deserves our sympathy for needless suffering.

Then there is the drunk driver who is the direct cause of this suffering. He or she may be the victim of circumstance—a person who became intoxicated once and did something foolish. But more often, the drunk driver is an habitual offender—an individual with a drinking problem, adept at hiding his or her drunkeness. The drunk driver is probably remorseful and may even have sought treatment since the accident.

At any rate, the drunk driver rarely has the resources or insurance to cover the damages the plaintiff is demanding.

Then there is the restaurateur. The restaurateur learns that an employee may have served an intoxicated individual when this suit was filed—one or two years after the accident allegedly occurred. Given the turn-over rate, the bartenders or servers who may have been involved are no longer on staff. The restaurateur has no way of knowing if the drunk driver was in the restaurant on the occasion in question or if the driver was visibly intoxicated when served a drink.

Often, the restaurateur's only defense is habitual practice. He or she may testify about the precautions which are taken to prevent guests from becoming intoxicated and the training given to servers. But the plaintiff's attorneys will point out that habitual practice does not mean that precautions were taken during the occasion in question.

Last, there is the jury—people like you or me—who will identify with the plaintiff. This kind of accident is no irrational, so needless. It is impossible to put a price on the anguish which had just been described to them. They are less concerned about discerning actual culpability than about obtaining these damages. They may very well decide the case with regard to financial responsibility rather than moral responsibility. That means the party who has the most assets or insurance will pay the greatest part of the damages.

Given this very sad situation, you can be sure that the restaurateur is about to become the victim of a victim. The restaurateur will not get justice at the hands of the law.

And the situation can be worse. In regard to liquor liability, we are seeing far too many plaintiffs who are trying to profit from a minor grievance with the encouragement of an attorney working for a contingency fee.

And we are seeing far too many instances of "scatter gunning." That is, naming every licensed establishment within a specific radius of an alcohol-related accident and forcing the owners to prove that they did not serve the perpetrator during the day in question.

All of us believe in the citizen's right to redress through the courts. This principle is sacred. It is the heart of our liability law. What we object to are abuses of this right—the kind of abuses which I have just been describing.

To eliminate or at least reduce this kind of abuse, dram shop laws must be reformed in States where they exist. The National Restaurant Association suggests the following changes:

First, dollar caps should be placed on the defendant's liability. Caps would assure a fair and equitable recovery for injured parties. At the same time, they lend the kind of predictability to awards that the insurance industry claims is necessary to curb unreasonable premium increases.

Second, liquor liability cases should be governed by the principle of "comparative negligence" and financial liability based solely on the defendant's percentage of responsibility for the accident. This would be a major attack on the "deep pocket" syndrome. Which sees individuals named as defendants primarily because they have insurance and can pay a steep penalty.

Third, advance notice of a liquor liability case should be provided by plaintiffs. Currently, the defendants first notice of a suit comes when the suit is filed. That in turn usually occurs at the end of the limitation period, which can be two years, three years, or even longer. At that point, the defendant often find it impossible to reconstruct events and present a strong defense.

Fourth, the time period for filing a suit under the statute of limitations must be reduced to a reasonable time frame.

These are just four changes we would like to see introduced. They would go a long way toward eliminating the abuses we are seeing.

But there is one even more basic change which is necessary if the crisis in service and product liability is to be ended. Our society must change its attitude toward civil suits. Our current attitude can be summed up in two sentences: "It doesn't matter if they are responsible. Their insurance will cover it." We have all heard that sentiment expressed in a thousand different ways. Americans take a very cynical attitude toward the right to redress. They seem to believe that any insured party is fair game. They cheer on the plaintiff, however, frivolous sr irrational his grievance. They applaud the windfall judgment as long as it goes against a well insured professonal, corporation or institution.

It is this attitude which is reponsible for the crisis in product and service liability.

We as a society tend to forget the obvious: All of us pay the penalty for every large court judgment. We pay it in higher insurance premiums. We pay it in loss of goods and services. We pay it in higher consumer prices. An over litigious society penalizes itself.

Social pressure is a powerful force which can modify behavior and modify the law. The time has come when our society must condemn abusers of our liability system. The alternative is an economy of scarcity and inflated prices, and none of us want that. We must work together to eliminate injustice and abuse in our liability system.

Thank you, Mr. Chairman, for this opportunity to testify before the subcommittee today, and I would be pleased to respond to any questions.

Chairman **Pickle**. We thank you for your testimony, and thank you for reminding us of your leadership in this field.

Before I go to the next panel member, what is liquor liability insurance? What does it actually involve? What are you, the restaurants, being held responsible for if someone drinks too much and causes damage?

Mr. **Sarasin**. We are being held responsible on an extension of strict liability concept, Mr. Chairman, although some jurisdictions, notably Washington and Virginia, very recently said that a restaurateur, when he obtains the liquor license, one of the requirements is that he not serve anyone who is visibly intoxicated, the courts have said and I think correctly, that that rule deals with obtaining a license, so if you serve someone who is visibly intoxicated, maybe they should pull your license, but it doesn't provide an automatic tort liability.

Most courts in the country have not taken that position. They have said that somehow the restaurateur is responsible to injured third parties. The person leaves the restaurant, involves himself in an accident and the person injured in the accident sues the restaurant, again the deeper pocket is usually the restaurant.

We don't believe we are the cause in that situation.

The other problem if I may just take a moment, Mr. Chairman, is that the law ordinarily says a restaurateur shall not serve someone who is visibly intoxicated; the law for driving under the influence is, frankly, a much lower standard, the 0.10 as it is in many States or lower, does not necessarily mean "visibly" intoxicated.

So you are putting the burden really on the basis of strict liability, the burden on the restauranteur that almost no one, absent a blood test as they leave the place, could satisfy.

Chairman PICKLE. Well, I think your recommendation is a good one and we appreciate the four points you made.

Now we will ask Mr. Norman Sherlock, American Bus Association, to proceed.

STATEMENT OF NORMAN R. SHERLOCK, PRESIDENT, AMERICAN BUS ASSOCIATION

Mr. SHERLOCK. Thank you, Mr. Chairman. We appreciate this opportunity to testify on a problem which has reached crisis proportions for our members.

The association's 3,500 membership includes private bus companies and a wide range of businesses which are involved in travel and tourism. All are affected in some way by the insurance crisis.

The scope of our dilemma can be seen in the following examples: A motor coach operator who paid $120,000 a year ago for coverage now has to pay $775,000; a theme park that paid $100,000 for insurance in 1985 now pays $665,000; a small hotel/motel that paid $38,000 now must pay $100,000.

These are typical of what is happening. The results are predictable. At the least, the prices of services will go up where companies can adjust their rates. Where businesses can raise rates without pricing themselves out of the market they will be forced to do so. But that is not an option that is open to everyone.

The motor coach operator particularly is caught in a vice. He doesn't make enough profits to offset this cost and cannot raise his rates due to competition, so the answer is to reduce service and try to sell half his fleet to stay alive. Others are doing the same. Some won't be able to stay in business at all, as was the case with Shubat Bus Co., as you can see from the attachment to our testimony.

The resentment of our members wouldn't run so high if the insurance companies' action had not been so sudden or drastic—or if we felt that we were paying our fair share. However, there seems to be little correlation between the records or quality of our members and the astronomical rates that are being exacted.

It is our view that the operators and the travel/tourism industry are bearing a disproportionate share of the burden for the insurance companies' problem.

When the crisis hit, we surveyed 133 bus companies to determine if the drastic rise in premiums was due to accidents which caused the insurance companies to increase the premiums. The survey showed that in 1982 the companies paid premiums of $2,169 a bus and had a per-bus loss of $2,484. In 1983, the numbers were about the same. In 1984, the per-bus loss was $2,283, but premiums had jumped to $6,032.

This pattern appears to be the same for other segments of our membership. Motels, hotels, and restaurants, as well as theme parks have indicated that they did not experience losses which should prompt these drastic rates.

The situation has gotten progressively worse. Currently, bus companies are finding that the best rate they can get for coverage is a floor of around $8,000 a bus. Some companies have reported quotations in excess of $20,000 and today, many bus operators have been forced into assigned risk pools at extremely high rates.

Something needs to be done. The situation is out of hand.

Last year was the worst year for insurance company losses in history but one must consider how they got into this situation. Even though it is not entirely their fault, a good portion of it is.

At the same time, the insurance companies are not at fault, for the problem arises from our judicial system as well. As long as there is no sensible limit to litigation by everyone while judges keep expanding the definition of liability and juries produce astronomically high awards, the problem cannot be resolved. The whole issue of the judicial framework of this country needs to be addressed.

Given this background, what can be done?

First, continue and intensify the congressional inquiries to determine the facts about what has brought about this situation and the degree to which these astronomical rates are warranted.

Second, whether at the State or congressional level, it should be considered whether action can be taken to curtail insurance company abuses. They should be required at least to give interstate bus carriers 90 days notice of policy cancellations. This is a minimal but important step.

Third, explore legislation remedies to limit bus carriers' liability, as is the case with international airline service. We have no limit such as the airline's Warsaw Convention and unlike Amtrak, we don't have the Federal Treasury's deep pockets to reach into.

Fourth, amend the Risk Retention Act to make it easier for an industry and an association to develop their own domestic insurance company and program.

Fifth, give careful consideration to comprehensive tort reform at the Federal level. A good focal point would be the Justice Department's recently publicized set of findings and proposals. Any and all other alternatives should be explored.

Thank you, Mr. Chairman.

[The prepared statement follows:]

STATEMENT OF NORMAN R. SHERLOCK

PRESIDENT, AMERICAN BUS ASSOCIATION

I appreciate the opportunity to submit testimony concerning the insurance problem that confronts the intercity bus industry. The American Bus Association represents more than 3,500 companies involved with bus regular route, tour and charter, airport and commuter services and in businesses which are related to travel and tourism. All are impacted by the insurance problem which has reached crisis dimensions.

Currently, the bus industry is facing an unprecedented crisis caused by the lack of availability of reasonably priced insurance. This has been by far the industry's major problem this year and will continue so for the foreseeable future.

I. ESCALATING INSURANCE COSTS ARE THREATENING THE EXISTENCE OF MANY BUS COMPANIES.

Some companies have already gone out of business, been absorbed by others, or are on the brink of extinction, due to catastrophically high rates which appear to have little or no relationship to the loss experience or safety performance of carriers. In a recent survey, we looked at bus companies' premiums per bus both before and after their latest premium increase. On average, those annual premiums per bus went from $2,169 before the increase to $6,032. Currently, the best premium quotations are not under $8000 per bus. Some individual carriers have reported that they have received quotations in excess of $20,000 per vehicle.

To put the figures and our survey in context, the average bus industry gross operating revenue per bus in 1984 was $91,188.00.[1] The average industry net operative profit per bus was $1,600.00.[2] Thus, based on the survey results, the average premium cost per bus has gone from 2.4% of total revenue per bus to 6.5%, and the average premium increase is 2.5 times greater than the average per bus industry operating profit.

The problem is nationwide and is affecting both large and small carriers. Here are a few examples from around the nation. A bus company in Killeen, Texas that operates 52 buses had its premium increased 37% to $377,000.00. A company in Abilene, Texas that has 12 buses saw its premium increased 461% to $106,000.00. A bus operator in Springfield, Missouri with 7 vehicles reported that its premium escalated 661% to $72,000.00, and finally an operator in Portland, Oregon reports that the annual premium on its one bus went from $5,550.00 to $29,987.00. This 545% increase occurred despite a perfect operating record over the last three years.

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[1] An annual report at page 17. Gross operating revenue was $2.279 billion and number of buses was approximately 25,000.
[2] Ibid.

The two problems immediately of concern are cost and availability. We have seen changes in each. Many industry groups and government entities have held meetings and symposia to share information and to try to come up with solutions to the liability insurance crisis. At ABA's suggestion, members of the Travel and Tourism Government Affairs Council met in January to review the problem and to see what legislative action could be taken on both the federal and state levels. Council members discussed such things as the importance of industry unity, meeting with elements of the insurance industry and others who may be seeking reasonable tort reform, and trying to determine appropriate prototype legislation on such issues as tort reform and risk retention. A number of coalitions concerned specifically with the question of tort reform have emerged and more are in the offing. Certainly, this, along with liability limitation, is a recurring theme.

While industry coalitions seek solutions, the availability and price problems affecting us continue unabated. In December, the Transit Casualty Company, a long time insurer of buses, was declared bankrupt. It was the apparent victim of a series of problems, both internal and external, which even the enormous premium increases of recent months could not solve. The loss to the bus industry of its one-time largest insurer carries with it a heightening of availability problems for the entire industry, as well as the multitude of problems to insureds of Transit from immediate cancellations to future claims liability.

While debate rages over insurance company profits and losses, liability insurance costs continue to rise. In recent weeks, articles in the Washington Post reviewed the details of a debate between the insurance industry and both Ralph Nader and the National Insurance Consumer Organization. While we make no judgments on the validity of any argument over profits or losses, it is apparent that both insurance companies and we are being hurt by inappropriate jury awards to injured parties and the broadened concepts of liability accepted by the judicial system.

Our members' quandary is worsened by a lack of effective regulatory procedures to shut down operators who choose not to operate with the required minimum level of insurance. Most carriers in our industry conscientiously meet the minimum insurance standards even though the premiums have gone skyhigh, but a minority do not. These carriers pose a serious problem not only because they are inadequately covered, but also because their lack of insurance gives them a cost advantage over carriers operating legally. It is the responsibility of the Interstate Commerce Commission to shut these carriers down, but we believe that the ICC's enforcement effort in this regard has not been adequate. We understand the Commission's problem with budget constraints but that does not mean that the lack of adequate enforcement should be overlooked, or disregarded anymore. Careful attention needs to be paid by Congress to this area.

The ICC keeps bus insurance certificates on file and has a procedure for getting consent agreement from carriers who have received a notice of cancellation, agreeing that no operations will be conducted until a new certificate is filed with the Commission. However, the enforcement of these consent agreements has not been adequate.

The Department of Transportation also shares responsibility for ensuring that bus operators carry the minimum levels of insurance. Under Section 18(e)(1) of the Bus Regulatory Reform Act, the Secretary of Transportation has the authority to impose a fine of up to $10,000 a day for failure by a bus carrier to maintain adequate insurance levels. We are not aware of any fines that have been levied in the three years that this provision has been in effect.

We believe that it is essential both for the safety of the traveling public and the health of our industry for the ICC and DOT to start enforcing the minimum levels specified by law in an effective manner.

II. AS THE INSURANCE CRISIS CONTINUES, THE EFFECT ON THE INTERCITY BUS INDUSTRY CONTINUES TO GROW.

The effects of the crisis include the following:

- A reduction in fleet size by many operators. The sale vehicles, despite business levels justifying larger fleets, is conducted either to reduce the number of vehicles requiring insurance or to raise cash needed pay insurance premiums.
- The elimination of interstate operations by operators. By yielding their authority to operate on an interstate basis, these companies reduce their insurance levels to points at or above the generally lower domicile state requirements. Such a move lowers premium levels substantially and permits continued intrastate operations.
- Cessation of operations, sale of company or bankruptcy are each the documented result of high cost insurance.
- Reduction or elimination of coverage. Many companies eliminated collision insurance, placing investments of $100,000 or more at risk. Others have raised self retention levels substantially.

III. THE CAUSES OF THE CRISIS ARE BEYOND THE BUS INDUSTRY'S CONTROL ALTHOUGH THIS INDUSTRY IS UNIQUELY DAMAGED BY THIS CRISIS.

The factor that one would anticipate would be the culprit in sharply higher insurance premiums would be a substantially poorer accident or loss record on the part of a bus carrier. But that is not always the case. In terms of the whole industry, it certainly is not.

The National Safety Council keeps accident statistics on 141 bus fleets nationwide that make up well over 90% of the intercity buses being operated in this country. Their statistics indicate that in 1982, this group had 4.56 accidents per million vehicles miles; in 1983, it had 4.14 accidents per million vehicle miles; and in 1984, the rate was 4.24 accidents per million vehicle miles. Thus, there was not only no substantial worsening of the bus industry's accident record in 1984, the 1984 frequency figure (4.24) was actually lower than the average frequency figure for the last three years (4.32).

Nor is there any indication that the dollar cost of these accidents has jumped so dramatically that it would justify the premium increases. In 1984, the insurance and safety account for Class I carriers, which includes liability costs for accidents, rose modestly from 55.8 million dollars in 1983 to 58.9 million dollars, an increase of 5.6%. This experience was typical of the experience over the last five years (1980-1984). During that time, insurance and safety costs have risen from $47.2 million to $58.9 million, a 25% increase, or an average annual increase of about 6%.

ABA surveyed the accident loss record for the last three years of the companies on the Board of Directors. The survey showed that in 1982, the companies responding had a per bus loss of $2,484.00. In 1983, the loss was $4,108.00, but almost half of this loss resulted from one accident costing $5 million dollars; without that accident, the per bus loss for the group would have been $2,395.00. In 1984, the per bus loss was $2,283.00. Thus the 1984 per vehicle loss was the least of the last three years and certainly does not justify the extraordinary increases that we have encountered in 1985.

Another factor that is clearly not the cause of the problem is the insurance minimums that are imposed by the Bus Regulatory Reform Act. Section 18 of the BRRA recently increased the minimum liability insurance for buses in interstate service to $5 million dollars.

We feel very strongly that the statutory minimum imposed by the BRRA should not be changed. It is the minimum that should be carried by responsible bus operators. On a 50 passenger bus, this is only $100,000 of insurance per passenger. Many people carry substantially more than that on their private automobile, and it truly is the minimum that an interstate carried authorized to serve the public should carry.

There are several problems, however, with the higher insurance requirement, and again they relate to the enforcement question. Most certificated carriers have complied with the new standards already, but I have no doubt that there will be a minority of carriers that will not comply with the new standards. Given the present cost of insurance, the carrier not complying with the new standard will have a substantial cost advantage over the carrier operating legally. In the highly competitive environment created by the BRRA, this is a grave threat to the legal operator who is in compliance.

It is critical for the ICC and DOT to work together and to work with the industry to develop an effective program for expeditiously requiring all carriers to demonstrate that they have met the new standards or to cease their operations.

It appears that the investment and loss history of the insurance companies themselves is the real source of our problem. The insurance companies have suffered recently from lower investment income due to reduced interest rates and higher loss ratios caused by generally low premiums and escalating liability judgments. This has produced much lower surplus to premium ratios, this limiting the insurance companies' ability to write new policies.

This has meant that insurance companies have been able to pick and choose the risks that they will insure. They are naturally going to choose the safest insurance risk they can find, and a jar of pickles sitting on a grocery store shelf is inherently safer than a container full of people driving down the highway.

While we recognize that this is a large problem and recognize the insurance industry's problem, we are hard-pressed to understand why the bus industry should bear a disproportionate burden, particularly in view of our excellent safety and loss record. The transporting of people is viewed by insurance companies as inherently risky, of course, and the bus industry transports more people (350 million in 1984) than any other mode. Moreover, the bus industry has no general limitation on liability such as Warsaw Convention limitations that the airlines have for their international flights. In addition, the bus companies are generally small and unknown to the large insurance companies.

In addition, since bus operations are performed nationwide and are predominantly interstate in nature, bus companies must rely on insurance companies that are registered to do business in most or all states. Thus even though there are probably local or regional insurance companies that are interested in writing bus policies, they are effectively precluded from the market because of the difficulties and expense of getting licensed in sufficient states to serve a substantial segment of the bus industry. This means that bus carriers, because of the interstate nature of their operations, are captives to a small group of large insurance companies with nationwide coverage, and when these companies choose to stop writing bus insurance, bus company options are extremely limited.

These factors taken together mean that only a few companies are willing to provide insurance to bus companies and the rates are high. As a result, our survey has shown that the average per bus premium is now running approximately $12,000-$15,000, while the average bus losses in 1984 were approximately $2,200.00. Obviously, some relief is needed from this extraordinary situation.

IV. SEVERAL STEPS SHOULD BE TAKEN BY THE CONGRESS TO HELP THE BUS INDUSTRY WEATHER THE INSURANCE CRISIS.

The Bus Regulatory Reform Act has spawned a highly competitive bus environment through the entry of hundreds of new bus companies. I fear that many of these companies, particularly those trying to live within the confines of the law, will be driven out of business by the unprecedented insurance crisis. You need effective administrative and legislative action to prevent this from occurring. The following are the specific actions that we believe are necessary.

A. Congress should examine bus industry insurance rates and propose action to force these rates to reflect the insured's loss experience.

Insurance rates now bear absolutely no relationship to a bus carrier's loss experience. Our surveys have revealed an average per bus premium of $12,000.00 to $15,000.00 while the average per bus loss was $2,283.00, and have turned up case after case of carriers with perfect or near perfect accident records getting hit with triple digit rate increases. The worst of all worlds appears, however, in the pricing of liability insurance coverage for individual buses. Insurance prices for various fleets in various locations with differing loss histories are remarkably the same. We hear from bus operators all across the United States. They supply us data on fleet size and quoted prices for specific coverages. One insurance company writing bus insurance today, apparently quotes $11,000 per vehicle to virtually every request. This type of pricing of potential risks means that no true underwriting is being done. Insurance underwriters historically consider location, geographic operational area, loss or claim history, management attitudes, financial soundness, and operational practices. With this number of variables, sound underwriting procedures would seldom produce a duplicate quotation. Today, duplicate quotations seem to be the rule.

The worst effect of this practice is the disincentive for safety it produces. If two bus companies pay the same -- regardless of how hard one tries to reduce accidents and how little the other may do in the same area -- it is easy to see that safety costs, it does not save.

B. Insurance companies should be required to give bus carriers conducting interstate operations a minimum of 90 days of policy cancellation.

At present, insurance companies are only required to give interstate bus carriers and the ICC 30 days notice of intent to cancel a policy. In troubled times like these, that has been disastrous for many bus carriers. 30 days has been insufficient for many carriers to locate alternative insurance, and our survey reveals that a substantial number of carriers have been forced to shut down temporarily because of their inability to come up with alternative coverage after having received notice of cancellation.

This obviously is very damaging to the riding public. Bus companies provide essential transportation service for both regular route and charter customers, and when those services are unexpectedly disrupted, it is a serious problem. This is why Section 16 of the Bus Regulatory Reform Act retained substantial regulation of discontinuance of bus service and why the ICC continues to require "reasonable" notice of any bus schedule change (49 CFR 1063.6(b)).

To minimize service disruptions caused by short notice insurance cancellations, we recommend that legislation be enacted requiring insurance companies to give bus operators at least 90 days notice of cancellation, which we believe is the minimum necessary time for a bus carrier in today's market to explore all possible ways of getting adequate coverage.

C. Legislative remedies should be explored that would limit bus carriers' liability in such a way to bring insurance rates back down to a reasonable level for interstate bus carriers.

We recognize insurance rates have become a problem for all businesses and that the subject of liability limitations is a hotly contested one. But we have tried to show in this statement that the bus industry is in a uniquely different position that calls for special consideration.

Transportation of people is viewed as an inherently hazardous risk by the insurance industry, and we carry more people than any other mode. Congress has also recognized the greater risks involved in transporting people by requiring much higher minimums for bus carriers than for all motor freight carriers, except hazardous material carriers ($5 million dollars vs. $1.5 million dollars). Unlike the airlines, we have no limit on any part of our liability such as the Warsaw Convention, and unlike Amtrak, we do not have the Federal Treasury's deep pockets to rely on.

The sum of these factors is that this industry is in an unusually disadvantaged position to deal with the insurance crisis, and if some efforts are not made to "level our playing field", many in our midst will have difficulty surviving. Since bus service is the only public transportation available to most towns and communities in this country, Congress should take the steps necessary to preserve that service.

Such steps should include appropriate limits for bus carrier bodily injury liability, the open ended nature of which is of great concern to the insurance industry. These limits should be high enough so that the injured are properly compensated, but they should provide a reasonable cap on liability so that insurance companies can more precisely assess the risk in interstate bus operations and thus not impose premiums based on the uncertainty of open ended exposure. In addition, Congress should pass legislation that facilitates development of insurance market alternatives, such as self-insurance, or mutual insurance companies.

Limitations could also be placed on punitive damages. Punitive damages awards have become so large that insurance companies will no longer insure against them. Thus the bus operator will be solely liable for punitive damage awards. Here again, the open ended nature of this exposure is particularly damaging to the typical small bus operator.

D. Amend the Risk Retention Act of 1981.

The purpose of this would be to modify current law to make it easier and more feasible for small industries and/or organizations to, in effect, develop their own domestic captive insurance entities. Support should be given to measures like the bill currently being drafted by Representative Richard Schulze.

E. Congress should give careful consideration to comprehensive tort reform very quickly.

Although insurance has been generally regarded as a state matter, the problem is now so widespread and the outcry so strong from the grassroots all over America that the whole judicial framework needs to be looked at by Congress. Earlier this month, a Tort Policy Working Group established by the Domestic Policy Council recommended a number of reforms to alleviate the crisis in availability and affordability of liability insurance. The proposed reforms include:

- a return to fault-based liability,
- prohibition of joint and several liability except where defendants have acted in concert,
- limitation on non-economic damages,
- reduction of awards by collateral sources of compensation for the same injury,
- decrease of attorneys' contingency fees.

The Domestic Policy Council agreed that the Reagan Administration should support civil justice reforms at the Federal and State levels.

Tort and civil justice reforms are an essential step in allieviating the liability insurance crisis. Any and all other alternatives should be explored as well.

Competition, insurance costs stalling charter-bus business

By Tom Belden
Inquirer Staff Writer

A sharp growth in recent years in the charter-bus business — spurred in this region by the hotly competitive Atlantic City casino-charter market — is ready to come to a screeching halt because of huge increases in insurance costs and a glut of bus companies, industry officials say.

The first big upheaval in many years in the long-distance bus industry occurred only 3½ years ago, when Congress passed the federal Bus Regulatory Reform Act.

Just as deregulation laws enacted since the late 1970s brought new competition to the airline, trucking and rail industries, the bus act allowed hundreds of new charter-bus companies to begin fighting for business with each other and with older, established companies.

According to Interstate Commerce Commission statistics, more than 2,500 bus companies — two-thirds of the current national total — were granted federal operating licenses between 1982 and September 1985.

Now, soaring liability insurance costs plus the oversupply of buses, particularly among those trying to grab some of the Atlantic City casino-charter trips, will be driving many companies out of business this year, industry officials say.

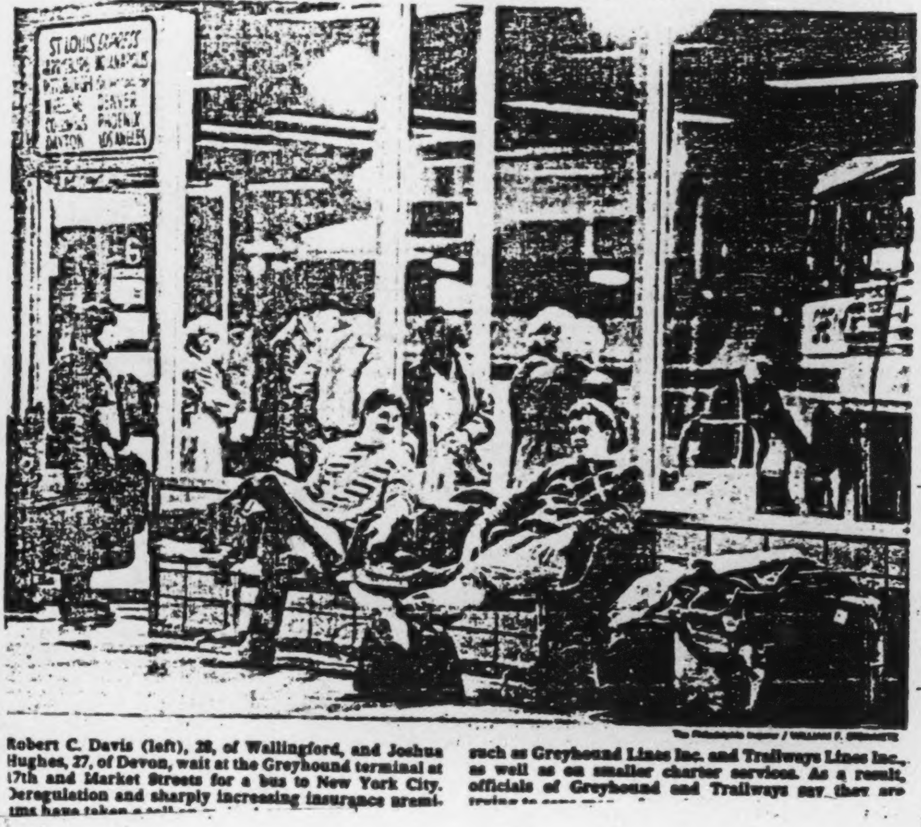
"Insurance costs have become enormous," said Nick Bade, a vice president of Trailways Lines Inc. who runs the company's casino-related operations from Atlantic City. Trailways, the bus-industry giant with headquarters in Dallas, runs more buses in and out of Atlantic City than any other company.

"We're going to see a lot of companies go out of business this year," Bade predicted. "This will be an interesting year in the bus business."

Already in 1986, Merz Highway Tours of

(See CHARTER BUSES on 13-H)

2 bus lines try shrinking their way to prosperity



The Philadelphia Inquirer / WILLIAM F. STEINMETZ

Robert C. Davis (left), 28, of Wallingford, and Joshua Hughes, 27, of Devon, wait at the Greyhound terminal at 17th and Market Streets for a bus to New York City. Deregulation and sharply increasing insurance premiums have taken a toll on [illegible] **such as Greyhound Lines Inc. and Trailways Lines Inc., as well as on smaller charter services. As a result, officials of Greyhound and Trailways say they are trying to** [illegible]

Stalling the bus business

CHARTER BUSES, from 1-H

Philadelphia, one of the country's oldest charter-bus operators, in business since 1916, has shut its doors because the cost of insurance became prohibitive, president Larry Gibbons said.

"We've never had any trouble with anybody," lamented Gibbons last week, who said he shopped among 40 insurance companies and found only one that was willing to write insurance — at an eightfold increase in premium costs.

"We've never missed paying a bill or missed a payroll," he said. "All of a sudden, the insurance crunch comes along and we're out of business. ... It's sad."

"It hasn't hit us hard yet because our insurance policy is not up until May, but it will," said Charles Major, owner of Major Tours, a three-year-old company with five charter buses that is typical of those that have begun since deregulation started. "In May, I'm quite sure the increase is going to be 300 percent."

Major said that when he started his business, premiums on $5 million in liability insurance for each bus were $2,100 a year. Today the premiums are $3,500, and "we're looking for it to be at least $10,000" under a new policy, if insurance can be obtained at all, he said.

Major believes that the only way he will be able to stay in business will be to sell three of his five buses and make cuts from among his six full-time and seven part-time employees. "I'm going to be doing the driving myself," he said.

Likewise, Trans-Bridge Lines Inc., a 45-year-old Bethlehem-based company that owns 37 highway coaches and operates both charter and scheduled service, has seen its insurance premiums jump from about $4,000 to $4,500 per bus to more than $11,500.

Especially during weekends this spring, many charter operators already have much of their equipment rented. That's because of the growing number of competitors that have pulled their buses off the road, said Tom JeBran, Trans-Bridge's charter operations manager.

"They're pulling them out of service because of the insurance," JeBran said.

At the same time, though, there are so many bus companies offering charter services now that groups seeking to rent a bus for an outing still can find one most of the time, JeBran and others said. The officials said problems in finding a bus to charter usually occur only on weekends and then in the peak months of April through June and September and October.

Trying to capture some of the work between Northeastern metropolitan areas and the 11 Atlantic City casino-hotels may precipitate a pitched battle within the charter-bus industry, industry officials said. And adding fuel to the competitive fire will be 17 daily runs of the "Gamblers Express," a train service that is scheduled to begin late in 1988.

An average of 1,000 buses a day disgorge passengers at the casino-hotels from cities throughout the Northeastern states, said Tom Dugan, president of the Atlantic City Bus Operators Association and president of Safety Bus Co., based in Pennsauken.

Between the Philadelphia area and Atlantic City alone, 24 bus companies are operating about 150 buses a day, Bade estimated. Trailways uses at least 50 coach-type buses — the air-conditioned, restroom-equipped kind commonly used for scheduled intercity service — to offer 70 round trips a day from the Philadelphia area to the casino-hotels or to the downtown Atlantic City terminal.

Most of the buses in the market are owned and operated by independent companies but work on what is called scheduled-line service, running between specific points in and around Northeastern cities and specific casino-hotels, he said. Numerous other buses arriving in Atlantic City are chartered specifically for day trips by groups on outings.

"The casino competition is perhaps the most intense in the transportation industry today," Bade said.

Most established bus companies, including Greyhound, Trailways and others, in the meantime, have been getting out of as much scheduled bus service as they can.

Executives of those companies say they have suffered mightily since the deregulation of the airlines and the stabilizing of fuel prices in the early 1980s, having lost much of their traditional market to discount airlines such as People Express, or to autos.

But the burgeoning number of small, often thinly capitalized charter-bus companies has cut sharply into the major operators' revenues, too, making it difficult for many of them to find profits even in charter work, spokesmen for Greyhound and other larger companies said.

For instance, an older, medium-sized company such as Starr Transit Co. of Trenton, which operates its own long-distance bus tours, competes in the Atlantic City market and does other short-distance trips, has higher labor costs than most competititors because it has a unionized work force, an executive said.

"We're going through labor negotiations right now, and we're going to have to ask our drivers for some concessions," said Starr president Mitchell Sussman. "The high times are all gone. The new companies have much lower labor costs."

As in other areas of transportation, there has been some benefit to consumers from deregulation. The hot competition among bus companies has held down the price customers pay, both individuals taking day trips to Atlantic City for gambling or sightseeing and groups that charter an entire bus.

The cost of taking a bus from Philadelphia to one of the Atlantic City casinos is only $8.90 round-trip, and on most trips, the customer is more than reimbursed in the form of casino slot-machine coins and a voucher good for restaurant food.

That cost has been held down by casinos competing with one other and bus companies competing for the casinos' business, bus company officials said. Mostly because of the increasing cost of insurance, some trips are about to increase to $10.90, Sussman said.

Likewise, chartering a bus to go from Philadelphia to Atlantic City and back has held steady at about $350 the last couple of years, because of the competition, and only recently has gone above $400, other executives said.

SHUBAT BUS COMPANY
CHARTER BUS SERVICE
117 EAST CASPIAN AVENUE P O BOX 275
CASPIAN, MICHIGAN 49915
PHONE (906) 265-9556

October 30, 1985

Mr. Norman Sherlock, President
American Bus Association
1025 Connecticut Ave. N.W.
Washington, D.C. 20036

Dear Mr. Sherlock:

I spoke with someone in your office about my being forced out of business by the astronomical insurance premiums that were predicted for my small company as of November 1, 1985.

We have been in business for sixteen and one half years, with a very good loss record, and have been forced to pay increasingly higher payments every year. This we accepted but the 300% increase that was predicted for my company was absolutely intolerable.

We have been preparing for an Auction which will take place on November 9, and there will no longer be a bus company in this area to serve the needs of the public.

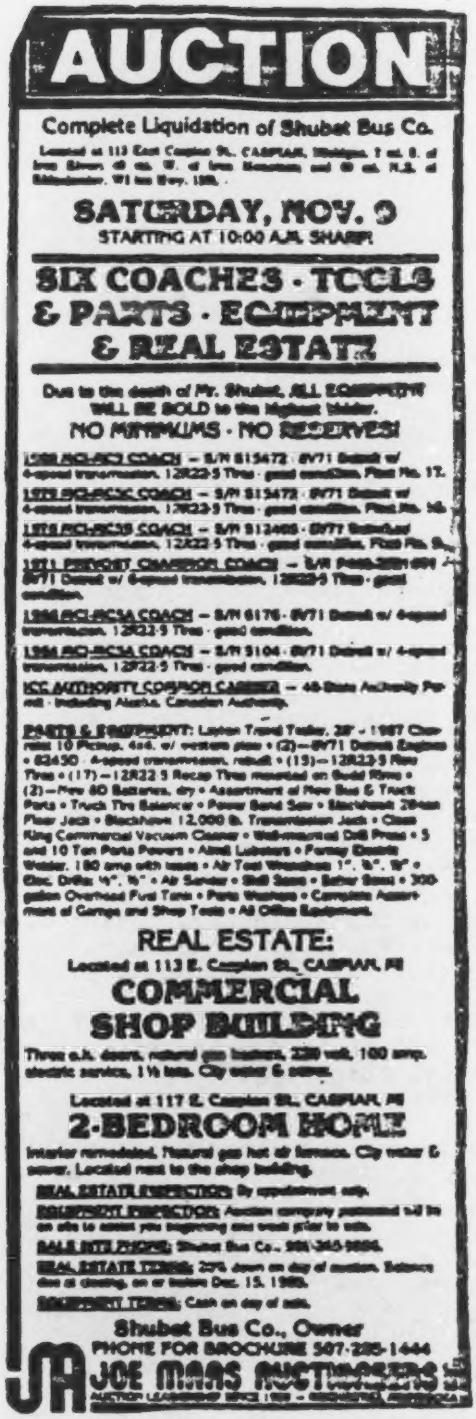
I have contacted my State Senator, Joseph S. Mack, and Congressman, Robert W. Davis, concerning the insurance dilemma months before my expiration date. I sent them copies of all information that came to me, and requested some assistance through their offices. To date nothing has been done to alleviate the insurance problem, so I have no alternative than to give up, and hope there will be some survivers after this is over.

I am a minority women in business, since the death of my husband March 12, 1984.

Sincerely,

Dorothy E Shubat

Dorothy E. Shubat



AUCTION

Complete Liquidation of Shubet Bus Co.

Located at 113 East Campion St., CASPIAN, Michigan. 7 mi. S. of Iron River, 40 mi. W. of Iron Mountain and 90 mi. N.E. of Rhinelander, WI on Hwy. 189.

SATURDAY, NOV. 9

STARTING AT 10:00 A.M. SHARP!

SIX COACHES · TOOLS & PARTS · EQUIPMENT & REAL ESTATE

Due to the death of Mr. Shubet, ALL EQUIPMENT WILL BE SOLD to the highest bidder.

NO MINIMUMS · NO RESERVES!

1980 MCI-MC9 COACH — S/N 813472 · 8V71 Detroit w/ 4-speed transmission, 12R22-5 Tires · good condition, Fleet No. 17.

1979 MCI-MC5C COACH — S/N 813472 · 8V71 Detroit w/ 4-speed transmission, 12R22-5 Tires · good condition, Fleet No. 16.

1978 MCI-MC5B COACH — S/N 812405 · 8V71 Detroit/Dual 4-speed transmission, 12R22-5 Tires · good condition, Fleet No. 9.

1971 PREVOST CHAMPION COACH — S/N [illegible] · 8V71 Detroit w/ 4-speed transmission, 12R22-5 Tires · good condition.

1966 MCI-MC5A COACH — S/N 6176 · 8V71 Detroit w/ 4-speed transmission, 12R22-5 Tires · good condition.

1964 MCI-MC5A COACH — S/N 5104 · 8V71 Detroit w/ 4-speed transmission, 12R22-5 Tires · good condition.

ICC AUTHORITY COMMON CARRIER — 48-State Authority Permit · Including Alaska, Canadian Authority.

PARTS & EQUIPMENT: Layton Travel Trailer, 28' · 1987 Chevrolet 10 Pickup, 4x4, w/ western plow • (2)—8V71 Detroit Engines • 82450 · 4-speed transmission, rebuilt • (15)—12R22-5 New Tires • (17)—12R22-5 Recap Tires mounted on Budd Rims • (2)—New 8D Batteries, dry • Assortment of New Bus & Truck Parts • Truck Tire Balancer • Power Band Saw • Blackhawk 20-ton Floor Jack • Blackhawk 12,000 lb. Transmission Jack • Clean King Commercial Vacuum Cleaner • Wall-mounted Drill Press • 5 and 10 Ton Porta Powers • Alemite Lubesters • Forney Electric Welder, 180 amp with leads • Air Tool Wrenches 1", ¾", ½" • Elec. Drills: ½", ⅜" • Air Sander • Skill Saws • [illegible] • 300-gallon Overhead Fuel Tank • Parts Washers • Complete Assortment of Garage and Shop Tools • All Office Equipment.

REAL ESTATE:

Located at 113 E. Campion St., CASPIAN, MI

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Three o.h. doors, natural gas heaters, 220 volt, 100 amp. electric service, 1½ lots. City water & sewer.

Located at 117 E. Campion St., CASPIAN, MI

2-BEDROOM HOME

Interior remodeled. Natural gas hot air furnace. City water & sewer. Located next to the shop building.

REAL ESTATE INSPECTION: By appointment only.

EQUIPMENT INSPECTION: Auction company personnel will be on site to assist you beginning one week prior to sale.

SALE INFO PHONE: Shubet Bus Co., 906-265-[illegible].

REAL ESTATE TERMS: 20% down on day of auction. Balance due at closing, on or before Dec. 15, 1985.

EQUIPMENT TERMS: Cash on day of sale.

Shubet Bus Co., Owner

PHONE FOR BROCHURE 507-285-1444

JOE MAAS AUCTIONEERS LTD.

AUCTION LEADERSHIP SINCE [illegible] — ROCHESTER, MINNESOTA

Chairman PICKLE. Thank you.

Now Mr. Edward Stimpson, president of the General Aviation Manufacturers Association.

STATEMENT OF EDWARD W. STIMPSON, PRESIDENT, GENERAL AVIATION MANUFACTURERS ASSOCIATION

Mr. STIMPSON. Thank you, Mr. Chairman. I will summarize my statement.

Last year General Aviation had its best safety record ever in terms of rates and total number of accidents according to the NTSB. Yet we saw our product liability costs go just the opposite direction.

As you will note from our testimony, the average cost per airplane now is $70,000 for liability insurance. This doesn't include other associated costs of accident investigations, in-house work and other things.

We have in our industry cases where in the last 4 years product liability insurance costs have risen by some 3,000 percent. Obviously with these sorts of costs, it has had a major impact on sales, it has affected employment; it has caused shutdown and slowdown of our production lines.

It has also affected our international competitive status and just recently, the International Trade Commission came out with a very comprehensive report about our industry, and this was a major topic in that report.

We are suffering in the international marketplace because of the product liability situation in the United States.

Legislation has been introduced in the Congress, H.R. 4142, and 27 of our colleagues are cosponsoring this bill which is now before the House Judiciary Committee.

This legislation would take many of the recommendations that Judge Bell talked about this morning, and that the staff briefed you on, according to the administration's report.

We are strongly supportive of this legislation, it attacks the issue of joint and several liability, statute of limitations, punitive damages, and we are hopeful that Congress will act on this bill. As manufacturers, we do make mistakes, and we should be held responsible for our products.

But in closing, I would just like to cite you an example of a recent case involving a 26-year-old airplane down in Florida, sat in the rain for several days, the pilot got in without adequately draining his tanks, took off, crashed, thank God nobody was hurt, he walked away, nobody was killed in this 26-year-old airplane, he sued for the cost of the airplane, plus other damages of $33,000, the manufacturer was awarded $28,000 to pay off the costs, he appealed, on punitive damages, 10 days ago he received $1 million punitive damage award because the manufacturer had not adequately warned about draining his tanks.

Well, that was even more than he asked for.

When you see this sort of award coming down, you have got to recognize as you do that something is out of control.

That is why we welcome your hearings to bring light to this overall subject of the product liability and liability insurance crisis, and urge your support of H.R. 4142.

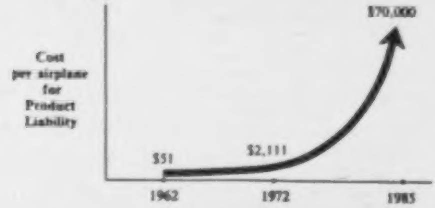
Thank you very much.

[The prepared statement follows:]

STATEMENT OF
EDWARD W. STIMPSON, PRESIDENT
GENERAL AVIATION MANUFACTURERS ASSOCIATION
BEFORE THE
HOUSE WAYS AND MEANS OVERSIGHT COMMITTEE
MARCH 24, 1986

I am Edward W. Stimpson of GAMA whose members manufacture general aviation airplanes, engines, avionics and related components. We appreciate the opportunity to discuss liability insurance -- its cost, availability and impact on trade in our industry. It is clearly one of our industry's top legislative issues, and we welcome the Committee's interest in this rapidly growing problem.

I say rapidly growing based on our experiences of the past few years. The accompanying chart reflects the skyrocketing costs of liability insurance despite a steady downward trend in general aviation accident rates which, according to NTSB, reached record lows in 1985. Clearly, one does not justify the other.



This alarming increase in liability insurance costs, which averaged almost $70,000 per airplane in 1985, has severely impacted the price of the private, piston-engine powered airplane. This class of airplane has historically accounted for approximately 80 percent of our unit sales. Several companies have been forced to discontinue production of most models of their piston-engine powered airplanes.

But how does this crisis affect our trade competitiveness? In a word, significantly. It is true that if foreign manufacturers wish to market their products in the United States -- and most of them do -- they are subject to the same tort system our domestic manufacturers are. But the liability of the manufacturers of foreign airplanes in U.S. service is technically limited to the assets of the manufacturer's U.S. marketing arm whose pockets are very shallow compared to those of U.S. manufacturers. Moreover, their liability overseas is determined by foreign courts that continue to demonstrate restraint in tort judgments. Conversely, U.S. aircraft anywhere in the world are subject to litigation in the U.S. court system with its record of huge judgments and settlements. Hence, the liability risks faced by U.S. manufacturers far exceed those of our foreign competitors, and the cost differentials constitute a competitive price advantage for the foreign manufacturer.

Another significant insurance cost advantage enjoyed by our foreign competitors is based on the number of aircraft in service that must be covered by a given manufacturer, regardless of the airplane's age. U.S. manufacturers must cover their proportionate share of the risks attributable to a fleet of over 200,000 U.S. airplanes. For example, as of December 31, 1984, according to FAA statistics, there were an estimated 164,000 single-engine and 25,000 multi-engine piston-powered aircraft in the U.S. We estimate that 98% or more are U.S.-built. That is an enormous and aging fleet for which our manufacturers must provide insurance at great cost -- a cost not incurred by our foreign competitors whose fleet risk is but a small fraction of ours.

A third foreign competitive advantage is in the commuter and business aircraft markets which, given the erosion of the piston airplane market we have identified, is even more important. It is highlighted in the U.S. International Trade Commission Publication 1817, dated March 1986: "Competitive Assessment of the U.S. Commuter and Business Aircraft Industries." It points out that "several foreign producers are government-owned and "enjoy important competitive advantages" including "preferential access to materials and labor, and the availability of capital for both operations and research and development." The report also reaches the following conclusion:

> "Foreign producers of commuter and business aircraft generally do not bear the same type or amount of product liability insurance burdens that domestic manufacturers endure. This is partly due to the fact that it is very difficult to recover damage claims from companies located overseas. Also, foreign industry officials state that since they chose not to produce and/or sell smaller aircraft, their firms do not have as high a level of product liability insurance to add into the price of their airplanes."

The ability of the U.S. manufacturers to maintain their competitive posture is suffering, not only because we do not enjoy the types of government support accorded our foreign competitors, but because the risks associated with the introduction of some new technology products are simply too great to bear under our current tort system. One of our member manufacturers' presidents testified before the House Science and Technology Subcommittee on Transportation, Aviation and Materials last October. He stated his company had "scrapped a year's worth of marketing and engineering research on a totally new electronic ignition product" which would have "significantly improved the performance and maintenance expense on today's piston aircraft engines." The reason: product liability risk.

Given the cost advantages enjoyed by our foreign competitors through government subsidies and lower insurance costs, the key to the viability of the U.S. industry has been its technological leadership. If the application of new technology is deterred because of the liability threats embodied in our nation's litigious society, then the future of our general aviation industry is cloudy indeed.

Through 1981, our industry enjoyed a positive balance of trade. Since then, our annual industry trade deficit grew to $350 million in 1984 alone. In fairness, I must identify a number of contributing factors: world-wide recession, high interest rates, the over-valued dollar, foreign tariff and non-tariff barriers, the continued importation of commuter aircraft, and the rapidly increasing costs incurred by U.S. manufacturers due largely to liability insurance cost escalation. We see improvements in the U.S. and many foreign economies; interest rates are down; the dollar has moved to more realistic levels; tariff and non-tariff barriers could be reduced through ongoing bilateral negotiations and the next round of GATT discussions. But skyrocketing liability costs may well offset these other welcome trade prospects and further cripple the U.S. general aviation industry.

In conclusion, Mr. Chairman, I would like to reiterate what our industry spokesmen have said repeatedly. We as manufacturers accept responsibility for our products, but product liability costs are adversely impacting sales, undermining our international competitiveness, impeding the application of new technology, and costing jobs. H.R. 4142, the "General Aviation Tort Reform Act of 1986," has been introduced in the House. It contains a number of provisions which would resolve many of the problems facing our industry while treating both plaintiffs and respondents fairly. Its passage would significantly enhance our international competitiveness. We would welcome your support of this bill.

Chairman PICKLE. Thank you, Mr. Stimpson.

Were you here this morning when Attorney General Bell testified?

Mr. STIMPSON. Yes.

Chairman PICKLE. About the limitations?

Mr. STIMPSON. Yes, and I am certainly in accord with the major recommendations. I told Judge Bell afterwards that most of the recommendations he talked about were contained in H.R. 4142. I was pleased to see that.

Chairman PICKLE. H.R. 4142, I assume, is meant for aviation?

Mr. STIMPSON. General aviation liability, yes.

Chairman PICKLE. But it can serve as a pattern.

What happens if insurance is not available in your particular areas? Are you closing operations? Just going out of business? What happens?

Mr. SHERLOCK. Let me take a shot at that.

Where operators are not able to obtain insurance to meet the Federal requirements of $5 million a bus for the larger bus, they do have to either find some way to get into the assigned risk pool which is one way to get coverage outside the private market, but if they cannot do that they do have to cease operations.

Companies are going out of business and we expect there will be hundreds of them before the end of this year. It will reduce the level of service to the public very substantially in many areas.

Chairman PICKLE. Are they going to self-insurance?

Mr. SHERLOCK. We have the same problem in the truck and bus industry. We don't have regulatory flexibility to go to self-insurance. Only the large ones, Grayhound and Trailways can do that.

We have asked the ICC in a proceeding to allow this for smaller carriers and we are working with DOT to get that flexibility. We would appreciate support from this committee for it.

Chairman PICKLE. Ms. Batts, I assume that is what you meant when you said you do not have in the trucking industry the same option as other businesses.

Ms. BATTS. That is correct. Within the trucking industry, as with the bus industry, companies don't have the option of running bare, that is running with no insurance.

Second, where the company would like to self-insure and it has the financial ability to do so, under regulatory provision, it is not allowed to do so. I concur with Mr. Sherlock, any support we can get from this committee to push the ICC so it will ease up on its restrictions and to get DOT to institute some rulemaking on self-insurance would be greatly appreciated.

Chairman PICKLE. I notice several of you made specific recommendations—some of you just outlined the problem—but some of you made specific recommendations. Do you think these recommendations should be handled in a legislative way at the Federal level, or legislatively at the State level?

Mr. SARASIN. Mr. Chairman, we came to this crisis not as a result of legislative action. Generally tort law is a result of court decisionmaking, and it used to be a nice, slow progression, but suddenly it moved exponentially. I am very reluctant to recommend Federal solutions to the problem, but by the same token I don't see any other solution. I don't see the States acting in concert in such a way as to resolve the problem.

I think the only body that may do it—although it is an area of jurisdiction you have never exercised before—is frankly the Federal Government, at least to provide a standard body of law.

Chairman PICKLE. Mr. Stimpson.

Mr. STIMPSON. I don't think any single or simple answer is available. For example, if you don't have accidents, you don't have product liability. Increasing our safety record is very important, as in our case, but the time has come that that alone won't do it. The crisis speaks out for a Federal solution.

Mr. SHERLOCK. If I may speak on that, Mr. Chairman, some of the recommendations I set before the committee have to be carried out by the Congress. For instance, the changing of the Risk Retention Act so that associations and small industries can conduct its own insurance company. That is a requirement. I think in the past Congress has been very reluctant to regulate at the Federal level obviously, but we are not seeing that the States are going to overcome this problem. It appears to us that in fact so many people are affected at the grass roots, whether it is day care centers, athletic companies, bus companies, so on, that it is a nationwide problem that the Congress would be expected to address.

Chairman PICKLE. Well, I do not know what direction we will take in this. We are just one committee that has limited jurisdiction in this field, primary jurisdiction lies of course in Commerce and Judiciary.

I think there will be a reluctance on the part of the committee to be recommending extension of Federal jurisdiction. But you people are representing business now, most of you, and you are saying there is a level of responsibility that we should assume on the Federal level. How we can do it would be another matter, but I guess what you are saying as a group is that premiums have gotten so high you either cannot get insurance or you have to cut the business down just to be able to get insurance for what you have left, and that such limitation causes a real problem.

You go back 26 years on the airplane, for example. If you are held responsible for an accident when a fellow goes and has a drink and then runs over somebody, that is a problem. Your business is representing business groups saying we at the Federal level should take the lead in working with the States to correct the situation. Is that the message?

Mr. STIMPSON. Yes, and I think also, Mr. Pickle, you mentioned you are looking at it from the Commerce standpoint.

Though I went over it quickly, we are concerned as other industries are about the job situation and the ability of our foreign competitors who are not facing the situation we do in the United States here.

We have seen in our industry production lines closed because of the product liability problems. Our foreign competitors are in a different situation and as I pointed out, the International Trade Commission has done a pretty good job documenting this in their recent report, at least in our industry.

Ms. BATTS. Mr. Chairman, we support the establishment of some type of select committee in Congress so that all of the committees that are interested in this issue could get together. I'm certain all the people at this table who have testified before other committees believe there is a genuine concern in Congress for it to get involved.

Unfortunately, no one seems to know how to do it. Perhaps establishment of a select committee to bring together the diversity of congressional interests and jurisdictions may be a step in the right direction.

Chairman PICKLE. We have talked earlier today concerning the formation of some ad hoc committee possibly, or perhaps a select committee or even a national commission. But I think the problem is critical enough so that we should act as quickly as we can, and I think this committee will do that by working with other committees. I think we will also urge the States to be as active and aggressive in this field as possible in as short a time as possible, because this problem is so large that it can literally affect the fabric of our private enterprise system.

I thank you very much. I appreciate your testimony. It has been good testimony, with good recommendations and we thank you.

I will ask the next panel, Tom Potter, Robert Owens, and Harry Katz to come forward.

First, Tom Potter, president of the Petroleum Marketers Association of America. Mr. Potter. Then Robert Owens, director of insurance of Rohm & Haas Co. in Philadelphia, PA, and then Harry Katz, president, New York Metropolitan Region of the United Synagogue of America.

The Chair recognizes first Mr. Tom Potter, president of the Petroleum Marketers Association.

STATEMENT OF TOM POTTER, SR., PRESIDENT, PETROLEUM MARKETERS ASSOCIATION OF AMERICA

Mr. POTTER. Good afternoon, I am Tom Potter, and I am president of Tom Potter Oil Co. in Moorhead City, NC. I am appearing before the subcommittee today in my capacity as president of the Petroleum Marketers Association of America.

I commend you, Mr. Chairman, for conducting these hearings on an issue of critical concern to all small businessmen.

Like all small businessmen, petroleum marketers have a substantial investment in their businesses, an investment they do not want to see lost because of the unavailability or unaffordability of liability insurance.

The risks perceived by many to be the greatest and most difficult to ensure for a petroleum marketer is the storage of petroleum products in underground tanks. Public attention has focused on isolated instances where tanks have leaked and gasoline has seeped into the basement of homes.

The facts, however, simply do not substantiate the magnitude of concern over the problem, nor do they substantiate the difficulty marketers face in acquiring insurance for these tanks. In fact, the major insurance carrier for petroleum marketers, Federated Insurance Co., has indicated that in 1985, the average loss on an underground tank claim was only $29,000. This is contrasted to 1983 when the average loss was slightly over $50,000 per claim.

The lower cost per claim can be attributed to the fact that marketers are taking more precautions in the installation and monitoring of their underground tanks.

They are detecting potential problems at a much earlier point in time, hence the lower cleanup costs.

Yet despite all of this, underground petroleum storage tanks are being lumped with hazardous waste disposal sites and chemical storage facilities in the eyes of many insurance companies, and reinsurance companies.

As a result of the increasing difficulty in obtaining pollution liability insurance, and the higher costs when it is available, many marketers do not have such insurance.

The insurance problem which exists is not limited, however, to the availability and affordability of pollution liability insurance. It includes general liability insurance as well.

In my own personal instance, my general liability premiums jumped from $17,000 in 1984, to $41,000 in 1986. That is a 142 percent increase in 2 years. As I am sure you are aware, I am not alone in this predicament.

PMAA conducted a random sample of its members to determine the seriousness of the liability insurance crisis. What we found was very interesting.

The average premiums paid by the independent marketer who responded to the survey increased by 165 percent in 2 years. The coverage obtained for this insurance decreased slightly and the deductible increased.

In contrast to these higher premiums, the claims awarded to marketers have actually decreased by 24 percent in the same 2-year period.

Of those marketers that responded, 35 percent indicated that their company had been nonrenewed or canceled in the last 2 years. Once canceled, the average time it took to get new coverage was 2 months, although some marketers reported it had taken them up to 4 months to acquire new coverage.

The reasons given for termination or nonrenewal varied, but the most frequent was that the carrier no longer was interested in providing coverage to our industry.

This supports the theory that insurance companies in the late 1970's and early 1980's were more interested in chasing the premium dollar than they were with loss ratios.

Evaluating possible solutions to this dilemma is difficult, particularly for an association such as ours, which is not in the insurance business. Some have argued that the easiest course is to do nothing because the insurance industry operates in cycles and market conditions will eventually improve.

We have difficulty accepting that argument. Many marketers may be unable to ride this cycle out.

We also do not adhere to the philosophy that the source of the problem lies exclusively in reform of our tort laws or in a total restructuring of the insurance industry. We generally believe the cause of the crisis is widespread and solutions must address each aspect of the problem.

In summary, let me say that first, from the perspective of the businessman, we have to become better risk managers, we must take every step possible to reduce our liability and the likelihood of accidents occurring.

Second, our civil justice system must also be examined closely with an eye toward more accurately defining and assigning liability based on more who is at fault rather than who has the deepest pockets.

Third, the insurance industry must recognize it has not been the model of efficiency in the past several years, and that an industry with such a dramatic effect on the commerce of this country must expect Federal scrutiny.

Finally, the Federal Government must assert itself and acknowledge that this is a problem far beyond the boundaries of individual States, and that some of the problem is a direct result of laws that have been passed, that although well-intended have contributed to increasing substantially the liability insurance companies face.

In my prepared statement, we offered several specific recommendations for the subcommittee's consideration.

Thank you for the opportunity to appear, Mr. Chairman.

[The prepared statement follows:]

Statement of

Tom Potter, Sr., President

The Petroleum Marketers Association of America

Good morning Mr. Chairman and members of the subcommittee. My name is Tom Potter, Sr. and I am President of Tom Potter Oil Company in Morehead City, North Carolina. Potter Oil Company is a small, family owned business supplying both gasoline and home heating oil throughout northeastern North Carolina.

I am appearing before the subcommittee today in my capacity as President of the Petroleum Marketers Association of America (PMAA). PMAA, formerly the National Oil Jobbers Council, is a federation of 41 state and regional trade associations representing approximately 11,000 small independent petroleum marketers (see Appendix A). Collectively, these marketers sell half the gasoline and over three-quarters of the home heating oil consumed in America today. While virtually all of these marketers are small businessmen, if one combined their collective assets, they would rank 17th on the Fortune 500's list of companies. I am attaching a copy of a statistical fact sheet on PMAA which should assist you in understanding the scope of independent petroleum marketing (see Appendix B).

As you can see, the marketers we represent have a substantial investment in their businesses, an investment they do not want to see lost because of the unavailability or unaffordability of liability insurance.

The Petroleum Marketing Industry

Before explaining the nature of our particular insurance problem let me first elaborate on the petroleum marketing industry and the role of the independent marketer. Petroleum marketing can basically be broken down into three levels: manufacturing or refining, wholesale distribution and retail sales.

In reality, however, the lines are not so neatly drawn. Major integrated oil companies control the vast majority of the refineries operating in the U.S. today and are the source of much of the product an independent marketer purchases. These major companies, however, do not limit themselves to crude oil production and refining. Many also both wholesale and retail gasoline, home heating oil and a wide array of other petroleum products.

Oftentimes these major companies operate in direct competition with their wholesale customers for retail business. While this can and has created a multitude of problems for independent marketers, it creates one particular problem directly related to insurance. Most of the major companies self-insure their risks, therefore, they may be largely unaffected by insurance availability and affordability problems. However, independent marketers are generally not large enough to self-insure and must purchase insurance in the open market. Theoretically, if the cost of insurance increases, that higher cost could be passed through to the ultimate consumer. However, because marketers compete with major companies that self-insure and thus do not experience the higher costs, many marketers may have to absorb the higher premiums.

As indicated, independent marketers purchase their product from a refiner. Many marketers then transport that product in their own trucks. In order for these trucks to be admitted to a supplier's terminal, however, they must have certificates of insurance. Without such an insurance certificate a marketer's trucks could be banned from its supply source. This would require a marketer to utilize a common carrier. This in itself would not constitute a major problem since some marketers use common carriers almost exclusively. But as can be attested to by associations representing such carriers, they also are encountering incredible problems in acquiring insurance.

Once the product is loaded into a marketer's truck it generally goes either to its ultimate destination (i.e. a service station, a commercial account, etc.), or it goes to an intermediate terminal or bulk plant owned by the marketer. These bulk plants are generally above ground storage facilities at which product is kept until it is reloaded in smaller trucks to be distributed to smaller service stations, farmers, and homeowners (in the case of home heating oil). Product that goes to the service stations, to farmers and to commercial accounts (i.e. truck fleets, cab companies, etc.) is generally stored in underground tanks.

This is a simplistic explanation of the product distribution process. Some marketers, for example, may receive product by barge or by pipeline. But this explanation does provide a framework for identifying the possible risks for which most marketers need insurance.

Insurance Availability and Affordability

The risk perceived by many to be the greatest and the most difficult to insure for a marketer is the storage of petroleum products in underground tanks. Public attention has focused on isolated incidents where tanks have leaked and gasoline has seeped into the basements of homes. So-called "experts" have warned about the potential problem leaking underground tanks pose.

The facts, however, simply do not substantiate the magnitude of concern over the problem nor do they substantiate the difficulty marketers face in acquiring insurance for these tanks. In fact, the major insurance carrier for petroleum marketers, Federated Insurance, has indicated that in 1985 the average loss on an underground tank claim was only $29,000. This is contrasted to 1983 when the average loss was slightly over $50,000 per claim. The number of claims has, however, increased steadily. In 1985 Federated reports there were 134 claims. The lower cost per claim and greater number of claims can be attributed to the fact that marketers are taking more precautions in the installation and monitoring of their underground tank system. They are detecting potential problems at a much earlier point in time, hence the lower cleanup costs.

Marketers have an inherent economic interest to monitor their underground tanks and to take every reasonable precaution against leaks. Petroleum products are a valuable commodity. Until very recently, a marketer may have had up to $1.00 per gallon invested in product in those tanks. He has every incentive to prevent the loss of any of that product in any form.

Despite all of this underground petroleum storage tanks are being lumped with hazardous waste disposal sites and chemical storage facilities in the eyes of many insurance companies and reinsurance companies. Many of these companies are now unwilling to do what they are supposedly in business to do, that is assume risks even when the risk is a reasonable one from a historical perspective, as is the case with underground storage tanks.

As a result of the increasing difficulty in obtaining pollution liability insurance and the higher cost when it is available, many marketers are choosing not to purchase such insurance. I personally do not have underground tank coverage because the carrier I have used for the last eight years will not offer pollution liability coverage.

I could have purchased coverage from another carrier, but only if I gave that carrier my entire liability insurance business. I would have been happy to do that, but their premium for my general coverage was over $10,000 per year more than my current carrier. In addition, pollution liability coverage which would have covered only part of my facilities was another $10,000. This means the pollution coverage would have actually cost me $20,000 per year or half of what my overall premium was for all other coverages.

While I would prefer to have pollution liability coverage, it is not critical for me as with many of my fellow marketers. Many of my stations are in an area with a high water table and the underground tanks may be to a large extent under water. Because of the water pressure, a leak in one of my tanks would be almost immediately recognizable by water in the tank rather than gasoline in the water.

The insurance problem which exists is not limited however, to the availability and affordability of pollution liability insurance. It includes general liability insurance as well. In my own personal instance my general liability premiums jumped from $17,000 in 1984 to $41,000 in 1986, a 142 percent increase in two years. In 1985 my company lost $28,000. Approximately 30 percent of that loss was directly related to higher insurance premiums.

As I am sure you are aware, I am not alone in this predictament. I could provide a litany of horror stories about the difficulties marketers are having in obtaining affordable general liability insurance. Rather than citing specific examples, I would rather try to provide a total industry perspective.

PMAA conducted a random sample of its members to determine the seriousness of the liability insurance crisis. What we found was very interesting. The average premiums in 1985 paid by the independent marketer who responded to the survey was $36,175. This compares with $13,648 in 1983, a 165 percent increase in two years. The coverage obtained for this insurance decreased slightly between 1984 and 1985 and the deductible increased. The cost per dollar of insurance coverage, adjusted for deductibles, increased by 146 percent in two years. In contrast to these higher premiums, the claims awards returned to marketers has actually decreased by 24 percent in the same two year period.

Of those marketers that responded, 35 percent indicated that their company had been non-renewed or cancelled in the last two years. Once cancelled, the average time it took to get new coverage was two months. Some marketers reported that it had taken them up to four months to acquire new coverage. On average, marketers received approximately two months advanced notice of cancellation or non-renewal.

While the average time frame for notices of cancellation or non-renewal seem to correspond well with the average time it takes a marketer to find a new carrier, it is interesting to note that some marketers received as little as one day's notice of cancellation or non-renewal. This obviously places that marketer in an incredibly difficult situation since he no longer has a certificate of insurance and can no longer send his trucks to supply terminals to pick up product.

Interestingly, the reasons given for termination or non-renewal varied, but the most frequent was that the carrier no longer was interested in providing coverage to our industry. This supports the theory that insurance companies in the late 1970's and early 1980's were more interested in chasing the premium dollar than they were with loss ratios. A number of companies began writing insurance at discount rates in order to acquire marketer business.

Now that the market has firmed considerably, these companies are no longer interested in offering coverage to petroleum marketers. The results of this market withdrawal have been to place an incredible strain on those few companies left which still offer coverage. One company still interested in marketer business had to suspend taking on any new business for a period of two and one half months because it had reached its acceptable capacity levels.

The other effect of the market withdrawal by companies no longer interested in marketer business is a significant lessening of competition. The results of the PMAA survey show that one company supplies coverage to over half of the marketers that responded.

Possible Solutions

Evaluating possible solutions to this dilemma is difficult, particularly for an association such as ours which is not in the insurance business. Some have argued that the easiest course is to do nothing. The insurance industry is cyclical and market conditions will eventually improve. We have difficulty accepting that argument. Many marketers may be unable to ride out this cycle. Moreover, what causes the cycle in the first instance and what steps can be taken to prevent it from recurring?

We also do not adhere to the philosophy that the source of the problem lies exclusively in reform of our tort laws or in a total restructuring of the insurance industry. We generally believe the cause of the crisis is widespread and the solutions must address each aspect of the problem.

From the perspective of the businessman we have to become better risk managers. We must take every step possible to reduce our liability and the liklihood of accidents occurring.

Our civil justice system must also be examined closely with an eye toward more accurately defining and assigning liability based more on who is at fault rather than who has the deep pockets.

The insurance industry must recognize that it has not been the model of efficiency in the past several years and that an industry with such a dramatic affect on the commerce of this country must expect federal scrutiny.

Finally, the federal government must assert itself and acknowledge that this is a problem far beyond the boundaries of individual states and that some of the problem is a direct result of laws that have been passed that, although well intentioned, have contributed to increasing substantially the liability insurance companies face.

With this in mind, FMAA would like to offer several recommendations for the subcommittee's consideration.

First, Congress should consider making available insurance for those areas which private carriers are reluctant to insure such as pollution liability. While pollution liability coverage may be currently available for underground tanks, it is available on a greatly restricted basis and there are constant rumors that it may not be available at all in the future. Some industries already are unable to obtain pollution liability coverage. To deal with this problem Congress should make available such insurance with a program similar to the Federal Flood insurance or riot insurance programs.

Secondly, our civil justice system must be modified considerably. While PMAA is still analyzing the recommendations of the Tort Policy Working Group at the Department of Justice, we believe that many of their suggestions may have merit. These include the retention of fault as the basis for liability; that joint and several liability be eliminated; that punitive damages and pain and suffering awards be limited to a fair and reasonable amount; and that alternative dispute resolution mechanisms be developed.

Finally, Congress should consider the enactment of federal minimum standards for state regulation of the insurance industry. This would bring about a level of consistency in state regulation. In addition, the antitrust exemption insurance companies have under the McCarran-Ferguson Act should be re-examined to determine the extent to which the exemption is still justified. The question of whether the antitrust exemption has been a contributing factor to the current crisis should also be examined. The fundamental question is -- Should an industry with as great an impact on millions of businesses as the insurance industry has be totally exempt from any consistent federal scrutiny?

Thank you for the opportunity to appear, and I will be happy to answer any questions you may have.

ATTACHMENT A

MEMBERS OF THE PETROLEUM MARKETERS ASSOCIATION OF AMERICA

The Petroleum Marketers Association of America represents the independent petroleum marketers who are members of these state and regional trade associations:

- Alabama Oilmen's Association
- Arizona Petroleum Marketers Association
- Arkansas Oil Marketers Association, Inc.
- California Independent Oil Marketers Association
- Colorado Petroleum Marketers Association
- Independent Connecticut Petroleum Association
- Florida Petroleum Marketers Association
- Georgia Oilmen's Association
- Idaho Oil Marketers Association
- Illinois Petroleum Marketers Association
- Indiana Oil Marketers Association, Inc.
- Intermountain Oil Marketers Association
- Petroleum Marketers of Iowa
- Kansas Oil Marketers Association
- Kentucky Petroleum Marketers Association
- Louisiana Oil Marketers Association
- Michigan Petroleum Association
- Mid-Atlantic Petroleum Distributors Association, Inc.
- Mississippi Petroleum Marketers Association
- Missouri Oil Jobbers Association
- Montana Chapter, Intermountain Oil Marketers Association
- Nebraska Petroleum Marketers, Inc.
- Independent Oilmen's Association of New England
- Fuel Merchants Association of New Jersey
- New Mexico Petroleum Marketers Association
- Empire State Petroleum Association
- North Carolina Petroleum Marketers Association
- Northwest Petroleum Association
- Ohio Petroleum Marketers Association
- Oklahoma Oil Marketers Association
- Oregon Petroleum Marketers Association
- Pennsylvania Petroleum Association, Inc.
- South Carolina Oil Jobbers Association
- South Dakota Petroleum Marketers Association
- Tennessee Oil Marketers Association
- Texas Oil Marketers Association
- Virginia Petroleum Jobbers Association
- Washington Petroleum Marketers Association
- West Virginia Petroleum Marketers Association
- Oil Jobbers of Wisconsin, Inc.
- Wyoming Petroleum Marketers Association

The Petroleum Marketers Association of America is located at 1120 Vermont Avenue, N.W., Suite 1130, Washington, D.C. 20005. Telephone (202) 331-1198.

Chairman PICKLE. Thank you, Mr. Potter.

Mr. Potter, for the record, you are a petroleum marketer. Are you a distributor, agent or consignee? How would you classify your operation?

Mr. POTTER. I am a distributor, I buy from a major oil company and resell to service stations, commercial accounts, farmers, and also I have home heating contracts.

Chairman PICKLE. Your risk is that you buy the gasoline and store it in big tanks?

Mr. POTTER. Yes, sir.

Chairman PICKLE. Then you resell that to your customers?

Mr. POTTER. Yes, sir; that is correct.

Chairman PICKLE. Your insurance is going up—has gone up from $17,000 to $40-some-thousand?

Mr. POTTER. Yes, sir; in 1984 my insurance as $17,000 and in 1986 it is $41,000.

Chairman PICKLE. Have you suffered losses or had damages within your operation?

Mr. POTTER. We have had some small claims, yes.

Chairman PICKLE. What do you call small claims?

Mr. POTTER. Well, basically, Mr. Chairman, our biggest problem has been falling in septic tanks as we go around delivering fuels to homes. We have had losses that were nonchargeable, by that I mean that we have had a couple of wrecks that were not our fault. Our insurance company paid us and then they went in and collected from the person who was at fault.

Chairman PICKLE. I thank you. I just wanted that in the record at that point concerning the type of business you have.

Mr. POTTER. Thank you, sir.

Chairman PICKLE. Mr. Robert Owens, Director of Insurance, Rohm & Haas Co.

STATEMENT OF ROBERT P. OWENS, DIRECTOR OF INSURANCE, ROHM & HAAS CO.

Mr OWENS. Mr. Chairman, I am happy to be here today and have this opportunity to testify on behalf of Rohm & Haas Co. We are a major manufacturer of specialty chemicals for agriculture and industry with 44 manufacturing plants in the United States and abroad, and sales offices in major cities around the world. We are a Fortune 200 company with sales in excess of $2 billion annually. We employ approximately 11,500 people and compete worldwide against major foreign chemical companies based in France, the United Kingdom, Japan, and Germany.

I would like to make several points this morning which are slightly different from my written testimony.

The first point is that the inability to purchase adequate liability insurance at a reasonable price is a very serious concern to companies such as mine. I have responsibility at Rohm & Haas for both taxes and insurance. Major tax legislation of which you are well aware is now pending. It will probably cost my company millions of dollars a year in increased taxes, but I am spending far more of my time on insurance than I am on tax matters. I believe the insurance problem is far more serious to us than the current tax legislation.

Second, the inability of U.S. companies to purchase adequate liability insurance at a reasonable price is a threat to our international trade position, principally because it will place us at a cost disadvantage compared to our foreign-based competitors. Someone asked me if our inability to buy insurance wouldn't help us by reducing the premiums we pay. It won't. We will pay much more in 1986 for a lot less coverage than we had in 1985, and we may also pay more out of our own pocket to settle claims relating to 1986.

The unavailability of adequate insurance at a reasonable price is just a symptom of the real underlying problem, which is the American tort law, particularly its application to product liability. I have a lot of reasons to dislike insurance underwriters. They have canceled policies on me, and they have told me no at renewal time a lot recently. But the thought that the insurance companies are really the fundamental cause of the current insurance crisis seems ridiculous to me. The awards handed out by the courts are the real cause of increased insurance costs. All the underwriters do is determine when that cost hits you.

For manufacturers there is no real escape from the insurance crisis until we have amended the tort law and, in particular, the product liability law. Legislation resulting in a fair, balanced and uniform product liability law would start to bring away our runaway liability system under control. Specific proposals in this area are included in my written testimony.

Finally, I believe the problem is far more serious than most feel it is. In 1974 I was the director of corporate planning for Piper Aircraft in Lock Haven, PA. In my comments for the 1974 plan for Piper, I noted that product liability insurance costs had risen to the incredible height of 4 cents for each $1 of sales, and that if it continued, the recent rate of increase would eventually put us out of business. At the time about 25 percent of Piper's sales were exports.

Last week I talked with some friends at Piper and in the general aviation industry. The cost of product liability insurance is now 30 cents of every $1 in sales, which is considerably more than the direct labor costs of manufacturing an airplane.

While the industry manufactured more than 14,000 aircraft when I was there in 1974, only 2,000 were manufactured in 1985. While they exported 4,200 in 1974, they exported only 354 in 1985, while 250 were imported from France alone. It is a sad story, and it is spreading to other industries besides general aviation.

I left Piper in late 1974 and am now the director of insurance at Rohm & Haas Co. But the steep rate of increase in excess liability insurance costs is the same at Rohm & Haas as it was in Piper in 1974.

Without legislation to reform the tort law, I think what happened to Piper can happen to Rohm & Haas and many other companies. I believe the chemical and other industries face far more foreign competition today than the general aviation industry did in 1974. The high standard of FAA certification has always helped the general aviation industry in world markets, and they had a dominant market share—say 80 percent or better—in the early seventies.

The thought of this problem spreading beyond the general aviation industry is chilling to me, and I ask that you reform the tort law at the Federal level, if you can, to see that it doesn't happen to the chemical and other industries as well.

[The prepared statement follows:]

STATEMENT OF
ROBERT P. OWENS, DIRECTOR OF INSURANCE
ROHM AND HAAS COMPANY

My name is Robert P. Owens and I am the Corporate Secretary and Director of Insurance and Taxes for Rohm and Haas Company, headquartered in Philadelphia, Pennsylvania.

Rohm and Haas Company is a major manufacturer of specialty chemicals for agriculture and industry with 44 manufacturing plants in the United States and abroad and sales offices in major cities around the world. We are a Fortune 200 company with sales in excess of $2 billion. We employ approximately 11,500 people and compete worldwide against major foreign chemical companies based in France, the U.K., Japan and Germany.

Background

American industry faces a serious problem stemming from the unavailability of adequate insurance coverage and limits. Available capacity for insurance has essentially disappeared in these areas in the last 18 months. Following basic laws of economics, the remaining capacity has become extremely expensive. The reasons for the crisis are many. Among them are:

(1) previously underpriced insurance;

(2) long "tails" on the policies that have already been written. The tail is the period of time over which claims could be made against an insurer for a policy written in respect of a particular year;

(3) extremely expensive defense cost for certain types of claims;

(4) jury awards to plaintiffs that apparently reflect a desire to enrich an individual at the expense of a "big, rich company"; and

(5) verdicts based on something other than merit have created immense windfalls for the plaintiffs' bar, providing incentive for plaintiffs' attorneys to pursue questionable claims.

Faced with these developments, many companies that were previously willing to write insurance policies no longer will. As a result, the capacity they represented has disappeared.

Companies located in the United States are finding themselves at a competitive disadvantage because product liability insurance, and other forms of insurance are becoming unavailable at anything like reasonable rates. Rates for insurance in some areas have skyrocketed. Even worse, the coverage offered today (if offered at all) is often riddled with exclusions, so that the policies afford little protection. Finally, coverage is not available to many would-be insureds, on any basis, at any price.

Rohm and Haas Company has not been spared the effect of this problem. Overall, our insurance costs for 1986 are expected to be 140% of what they were in 198~~4~~5, even though we are buying less coverage than we had before. Moreover, the cost of certain major elements of our coverage have tripled in that period. Excess liability insurance is a prime example. Formerly a relatively small portion of overall insurance costs, the cost of excess liability coverage has grown so that in 1986 it is expected to be approximately one third of our overall cost of insurance, and the largest single item of insurance cost.

Effect on International Trade

This crisis in the availability and cost of liability insurance adversely affects the United States international trade position in several ways.

1. It encourages U.S.-based companies to manufacture their products overseas in order to obtain lower liability insurance costs for their manufacturing operations. Lower insurance costs will allow companies with foreign manufacturing operations to compete more favorably on a price basis in world markets. The effect of ~~their~~ this shift on the U.S. economy will be fewer jobs, fewer exports, lower tax revenues and more imports.

2. It discourages foreign-based companies from siting their new facilities in the United States. Instead, they will continue to supply the U.S. market by exporting into it, thereby avoiding the increased manufacturing costs which result from manufacturing in the U.S. tort law environment. This tends to increase imports, and results in missed opportunities to increase exports, tax revenues, and employment.

3. It encourages companies with available capacity overseas to use it, rather than available manufacturing capacity in the U.S. The result is fewer exports, lower employment, and more imports.

4. It discourages exports by increasing the cost of U.S.-manufactured products as compared to similar products manufactured outside the U.S. tort law environment. This results in lower employment and lower national and local tax revenues.

5. It encourages imports. To the extent the insurance cost differential exceeds shipping costs, foreign manufacturers enjoy a cost advantage over U.S. manufacturers in the U.S. market.

6. It may stop some products from being manufactured at all.

Aside from the location of manufacturing issue, it would seem the cost of insurance for a company that sells 50% of its products in the U.S. and 50% of its products overseas would be the same regardless of whether that company is a U.S. or foreign corporation. But this may not be the assumption being used by insurance underwriters. Aware of the exposure of the U.S.-based company to the U.S. court system, underwriters apparently are assuming that greater risk is involved in dealing with U.S.-based companies and are charging higher premiums.

Foreign-based companies, whose principal assets are not subject to judicial process in the U.S., over time will have a significant advantage over U.S.-based firms in U.S. markets. The foreign company's own courts will simply not honor the outlandish theories for recovery advanced by the U.S. plaintiff's bar. Thus foreign-based companies have a form of natural protection. A U.S. firm selling in foreign markets faces the possibility that if some claim is advanced against it for a real or imagined wrong, a U.S. court will take jurisdiction on behalf of foreign-located plaintiffs and apply U.S. legal theories, which would otherwise be unavailable in foreign markets. Consequently, the U.S. company faces serious liability risks even for their foreign operations.

Because of these risks, U.S. and foreign insurance companies become reluctant to write coverage for U.S.-based firms. Moreover, as companies drop out of the insurance and reinsurance business, the capacity that is available is more readily available to companies based in countries having more reasonable tort liability legal structures.

Recommendations for Congressional Review

We believe that Congress must address the crisis at hand. To help alleviate it, we propose the following recommendations for Congressional review.

A. Reform of the Nation's Product Liability Laws

The Senate Commerce Consumer Subcommittee recently completed two days of hearings on the issue of product liability. The testimony of witnesses at these hearings demonstrated that the need to reform our nation's product liability laws is widely recognized.

The present product liability system is breaking down under the weight of excessive litigation, exorbitant legal fees and unreasonable damage awards. The expansion of product liability has gone so far that reasonable casualty insurance is unavailable.

It is time for Congress to reform our product liability laws. A fair and balanced uniform product liability law would help bring our runaway liability system under control.

Such a bill should include appropriate standards for judging the adequacy of product design and the appropriateness of safety warnings. It should provide a clear presumption that a product meeting government safety requirements is reasonably safe. It should adopt the principle of comparative responsibility so that damages reflect the extent to which plaintiffs contributed to their own injuries. It should impose reasonable caps on damage awards, and sharply limit punitive damage awards which in recent years have become subject to jury abuse. We believe these changes would make a significant improvement in the current product liability system and would improve the outlook for insurance.

B. Tax Deductibility of Self-Insured Reserves

Since commercial insurance either is not available to the corporate community or is available only at a prohibitive cost, companies must explore other options to cover their legal obligations. To help companies meet this challenge, Congress should facilitate the use of these other options.

One important option is self-insurance. Unfortunately this option is limited because of an inability to take tax deductions for losses until they are paid.

We urge Congress to amend the Tax Code to permit corporations who elect to self-insure, either through a captive insurer or through reserves for expected losses, to deduct these reserves. A self-insurance reserve would almost always be less than the cost of commercial insurance, due to the reduced costs of overhead, profit, commissions and insurance premiums. Therefore, allowing a corporation to deduct its self-insured reserves should result in lower costs to the corporation. As reserves of the corporate self-insured and the commercial insurer serve the same purpose and are subject to the same claim of liability, there is no rational reason for differentiating between them for tax purposes.

C. Review Uninsurable Liabilities in Existing Laws

Recent federal environmental legislation has changed many of the basic principles of tort law. Superfund in particular departs from these traditional tort principles, imposing virtually absolute retroactive liability upon parties whose actions may have been completely lawful at the time they were taken. Moreover, courts have almost uniformly upheld the government's position that Superfund permits imposition of joint and several liability when the damages are indivisible. Thus complete recovery may be had from any one of the responsible parties.

Industry and its insurers could not foresee the novel principles of liability deriving from Superfund and similar legislation. Under some circumstances, Superfund may make liability a virtual certainty. This has led insurers to believe that environmental risk is uninsurable.

Congress should carefully study any new legislation to make sure that the liabilities being imposed are insurable. More fundamentally, the Congress should enact tort reform legislation to maintain the competitiveness of American industry.

Chairman **Pickle**. Thank you, Mr. Owens.

Mr. Harry Katz, president, New York Metropolitan Region of the United Synagogue of America.

Incidentally, Congressman Rangel had talked to me to be sure that you would be able to testify today.

STATEMENT OF HARRY S. KATZ, PRESIDENT, NEW YORK METROPOLITAN REGION OF THE UNITED SYNAGOGUE OF AMERICA

Mr. **Katz**. Thank you, Mr. Chairman. We will thank the Congressman for his permission and opportunity to be here today.

The United Synagogue of America represents 835 synagogues throughout the United States. The New York metropolitan region, of which I am president, represents 135 synagogues and 55,000 families in the New York area.

Our organization represents synagogue presidents and officers who work without salary but who are responsible for giving direction to 1½ million Jewish families in America. Our synagogues represent the conservative movement of American Jewry.

Periodically we meet with different groups of our synagogues leadership. Six weeks ago, in a meeting, we were awakened to an alarming situation.

It was reported to us that insurance rates were doubling, tripling, and in some cases a synagogue's insurance coverage was being terminated with no broker or company available to provide adequate coverage at any price.

To be left without the protection of insurance represents a real threat to the life of a synagogue, which is a sanctuary, a community center, a nursery school, a day care center, an afternoon school supplying the basics in religious faith and observance.

A synagogue prepares children for bar and bat mitzvah, also provides high school and adult education. The synagogue is a place for social events, for families to meet, for people in trouble to be counseled. It is a center where we sanctify and commemorate the rites of passage in life, birth, marriage, and death.

We decided to seek a short-term and a long-term solution to the problem. On February 4, 1986, I wrote to our congregations as follows:

> Many of our congregations have reported to us serious difficulties in obtaining comprehensive coverage for their synagogues (or, alternatively, exorbitant rate increases). Should your synagogue have an insurance program with which you are happy and would want to recommend, please contact me personally.

As a result of this letter, we received the names of five or six insurance agents who said that they would try to find immediate solutions for those synagogues whose insurance coverage has been terminated abruptly.

We have made three or four referrals. While some of the brokers to whom we referred our synagogues have attempted to obtain coverage for synagogues in trouble, we have not heard positive results thus far.

These synagogues, to the best of my knowledge, have not made frivolous claims in the past to their insurance companies.

There is one case where the Torah scrolls were no longer deemed insurable. We find this particularly distressing. Although Torah scrolls were being stolen a few years ago, a system of universal Torah registry was introduced which all but solved that problem.

The proposal to self insure, which has been adopted by some large groups, is impractical for us. While the United Synagogue is the largest synagogue group in the United States with 835 synagogues and 1½ million members, we are still too small to self-insure.

We were told that such a concept would be difficult to market to our constituent members, costly, and possibly disastrous.

So the approach which we are aggressively pursuing now is to find carriers who would put together for us an insurance program which could provide broad coverage for most of our synagogues.

I must, however, report to you that those companies that have responded optimistically to this idea are few. I know of one possible insurance carrier who will consider to undertake this, perhaps another. Our synagogues are clamoring.

If a synagogue is unable to obtain directors' and officers' liability protection, the volunteer officer or director of a synagogue is in an unenviable position.

While it is true, perhaps, that a synagogue can itself indeminify its board, this is a two-edged sword that bodes ill for the future volunteer in religious and community life. It is the volunteers who often form the backbone of services to the congregation and the community.

Who will serve on our youth programs, our ritual committees, our budget commissions, our executive committees?

Indeed, who will agree to become the president of such organizations and assume not only the unpaid burdens of community leadership, but possibly a financial risk, as well?

Again, we thank you for the opportunity to appear before you. Our written report contains several actual citations of situations where our congregations were either struck with exceptionally high rates for renewals or worst of all, could not get any renewals for their insurance coverage.

If the Federal Government suggests a possible solution, we certainly do not object, but there should be some measure taken to make sure that the carriers confront their responsibility to institutions such as our's.

Thank you very much for this opportunity, Mr. Chairman.

[The prepared statement follows:]

New York Metropolitan Region
THE UNITED SYNAGOGUE OF AMERICA
155 Fifth Avenue New York, N.Y. 10010 212/533-7800

MICHAEL W. FRIMER
Executive Director

HARRY S. KATZ
President

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We periodically meet with different groups of our synagogue leadership. Six weeks ago, in a meeting, we were awakened to an alarming situation. It was reported to us that insurance rates were doubling, trippling, and in some cases a synagogue's insurance coverage was being terminated with no broker or company available to provide adequate coverage at any price.

To be left without the protection of insurance represents a real threat to the life of a synagogue which is a sanctuary, a community center, a nursery school, a day care center, an afternoon school supplying the basics in religious faith and observance. A synagogue prepares children for Bar and Bat Mitzvah and provides high school and adult education. The synagogue is a place for social events, for families to meet, for people in trouble to be counseled. It is a center where we sanctify and commemorate the rights of passage in life, birth, a marriage and death.

We decided to seek a short term and a long term solution to the problem. On Feb. 4, 1986, I wrote to our congregations (see attached) as follows: "Many of our congregations have reported to us serious difficulties in obtaining comprehensive coverage for their synagogues or, alternatively, exorbitant rate increases. Should your synagogue have an insurance program which you are happy with and would want to recommend, please contact me personally."

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There is one case where the Torah Scrolls were no longer deemed insurable. I find this particularly distressing since while Torah scrolls were a few years ago being stolen, a system of universal Torah registry was introduced which all but solved that problem.

The proposal to self-insure which has been adopted by some large religious groups is impractical for us. While the United Synagogue is the largest synagogue group in the United States with 835 synagogues and a million and a half members, we are still too small to self-insure. We were told that such a concept would be difficult to market to our constituent members, costly, and possibly disaterous.

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As a final note, I must add the particularly difficult position a person like myself may find himself in in the near future. If a synagogue is unable to obtain directors' and officers' liability protection, the volunteer officer or director of a synagogue is in an unenviable position. While it is true, perhaps, that a synagogue can itself indemnify its board, this is a two-edged sword that bodes ill for the future volunteer in religious life who often forms the backbone of services to the congregation and the community. Who wil serve on our youth programs, our ritual committees, our budget commissions, our executive committees? Indeed, who will agree to become the president and assume not only the unpaid burdens of community leadership, but possibly grave financial risks as well?

The Insurance Crisis-Case Histories

1. Sheiris Israel
Bay Ridge Jewish Center
405 81st Street
Brooklyn, N.Y. 11209
718-836-3103

The Executive Director, Dr. Reuben Kagel reported that Sheiris Israel Which had paid $3,125.00, last year to insure its 11 Torah Scrolls was told by its carrier that these scrolls could not be insured this year. Numerous insurance companies were contacted, even Lloyds of London and no carrier could be found. The Synagogue was told that the system of universal Torah registration is not sufficient to protect the security of these scrolls from theft.

2. Temple Israel
108 Old Mill Road
Great Neck, N.Y. 22023
516-482-7800

The Executive Director, Vivian Krasnov told me that until April 15th of last year, she had been paying $27,000 for a multi-peril policy covering all aspects of their Synagogue's liability. This year, she could not get a multi-peril coverage but had to obtain a variety of insurers at a cost of $55,000. Temple Israel was notified a few weeks ago that the liability portion of their coverage will not be renewed. Why? The company decided that they will not write insurance premiums that are less than $150,000.

Temple Israel of Great Neck will therefore, shortly find itself without the protection of insurance coverage for its 700 member families, its Nursery School, and its School for Supplementary Jewish Education.

3. Jericho Jewish Center
Broadway & Jericoh Road
Jericho, N.Y. 11753
516-938-2540

The President of the Jericho Jewish Center, Mr. Alan Bessen, reported that he had held an insurance contract with Atlantic Mutual, an insurance company known for its coverage of Religious Organizations, for $11,000 a year in a three year contract. This contract was cancelled after one year. The reason given, Mr. Bessen said, was because special insurance programs for Religious Institutions had had their coversage amended so they would not include summer day camps, nursery schools, or catering operations. Therefore, many of the essentials services that a Synagogue provides, as well as its own access to kosher food would not now be covered under any insurance arrangement.

4. Beth El Synagogue Center
Northfield Road & North Ave.
New Rochelle, N.Y. 10804
914-235-2700

The Executive Director, Mr. Harvey Silton reported that New Rochelle which had been covered previously under a liability multi-peril policy for two million dollars at $9,000 a year and a three million umbrella policy at $2,000 a year which had been set to expire on February, 1986, was notified of termination of their policy. They have finally been re-insured. Their liability coverage has been reduced to one million dollars for which they are paying $36,000 a year for one-half a million dollars coverage and $25,000 dollars for the second half, for a total of $61,000 dollars a year. They have drop the three million dollar umbrella coverage which would have cost them $14,000 dollars a year or seven times its original price. Thus, for Beth El in New Rochelle, five million dollars in coverage which was costing them eleven thousand dollars yearly has now been reduced to one million dollars coverage with a two hundred fifty thousand dollars deductible at a cost of sixty-one thousand dollars year.

Mr. Silton reports that New Rochelle has not made claims against the insurance policy previously. In fact, it always covered small damages out of its own pocket.

Submitted
Harry I Katz
Pres.

Chairman **Pickle** We thank you, Mr. Katz.

Mr. Katz, have you or any of your synagogues—are you without insurance now?

Mr. **Katz**. At the moment we know of none. However, our report indicates that come April one of our major congregations in the New York area is threatened with the termination of coverage.

Chairman **Pickle**. Have you been able to obtain insurance for all your Torah scrolls?

Mr. **Katz**. So far, yes, it is included in the general hazard insurance that a congregation will carry, but the problem goes way beyond the Torah scrolls which we can almost encase in fireproof or burglary proof containers.

It is more important our people are covered.

Chairman **Pickle**. What is your prospect if you are too small for self-insurance?

Mr. **Katz**. That is our drastic and desperate fear. The fact is that some of our day care centers will have no choice but to close down. We couldn't possibly expose the volunteer boards, offices, teachers, principals of these congregational schools and day care centers to operate without some financial backing for them in their profession and occupation.

Chairman **Pickle**. Mr. Anthony.

Mr. **Anthony**. Thank you, Mr. Chairman.

Mr. Owens, do you think the Congress should change underwriting practices to correct the current system we are now struggling under?

Mr. **Owens**. I don't think that changing underwriting practices will get at the core of the problem.

If I had to decide blame or fault, I would say it is about 10 percent poor business analysis by the insurance industry over the last few years, and about 90 percent with the tort system. The tort system is where the problem originates.

Mr. **Anthony**. Well, in the tort system. The Rand study basically said that the tort system is not broke. When adjusted for inflation, population, that the bulk of the verdicts and judgments were stable over the last 20 years.

We have had many, many witnesses that have come and testified for their associations. They have said that the premium that has been charged in 1986 bears no relationship to their loss experience over the last several years.

The insurance people themselves come in and testify about the psychological fear of the big judgment, and as a result, they run the premiums up.

All of that practice within the insurance industry itself does not concern you?

Mr. **Owens**. I think that the insurance industry has to make its own judgments about underwriting risk. I think that from our standpoint, as long as there is a reasonable level of competition in that industry and I think there is, that they will sort things out.

I guess one thing they have to face is concern about the big bang, and that does tend to institutionalize in a way, some types of insurance.

Mr. **Anthony**. For 7 years, the insurance industry did not worry about the tort system. For 7 years they used predator pricing, and they got into all sorts of businesses. And so for 7 years the insurance industry said, I am not concerned about the tort system.

So how can they come in today and say it is the tort system, or how can you sit there and defend them for saying it is the tort system that is at fault?

For 7 years they totally ignored 90 percent of the falls then. For 7 consecutive years they went out and underpriced their market to get as many premium dollars as they could. They didn't gripe about the tort system for the last 7 years.

Mr. OWENS. I can't comment on the extent to which they have griped about the tort system.

I think we have seen, with respect to our industry and with respect to others, some fairly major settlements during that period.

We have seen our own case that we settled for amounts higher than we anticipated, and we naturally expect that this would be reflected in the premiums we would pay.

Mr. ANTHONY. Did the premium have any relationship to the loss experience over the last few years, the last 7 or 8 years?

Mr. POTTER. No, sir, I think I agree with you 100 percent, that the insurance industry needs to look at itself.

I know 8 years ago, when I was putting my business out for bids, the company that I now am doing business with immediately quoted us a 10-percent discount.

You are correct that what they were after was to get the premium dollars with all disregard to the loss ratios.

Mr. ANTHONY. Mr. Owens, do you feel that insurance is something that is needed and necessary in business?

Mr. OWENS. Yes, it certainly is.

Mr. ANTHONY. You consider it to be essential?

Mr. OWENS. Yes.

Mr. ANTHONY. Do you think we need a more closely regulated insurance process so there would be a more orderly and rational marketplace with a reasonable, consistent supply of affordable coverage?

Mr. OWENS. No.

Mr. ANTHONY. You are saying the marketplace will take care of it. The insurance companies are only 10 percent at fault. Leave it up to those managers; they will sort it through, change the tort system, and everything will be fine.

When the insurance people testified at the first day of this hearing, I asked them, "What lines of insurance will you lower the premiums on, and what lines of insurance will you spread out into if we revise the tort system?"

And they won't give you an answer.

Mr. OWENS. Well, I guess I think that in order to be able to underwrite a risk, it has to be a reasonably estimatable risk, at least in the broad sense of the word, and I think that the insurance industry has, itself, taken a step in the right direction to make it easier for them to estimate their real liability.

They switched with respect to liability insurance from the occurrence form to a claims-made or claims-first-made form within the last year. I think that that will make it much easier for them to close a given year with respect to their final liability than it has been in the past, and therefore, make it easier for them to conform the current premiums to the current experience in the claims settlement marketplace, if you will.

That is a major step. It has to be a major help to them.

Certainly, it is awfully tough for them to forecast where the liability as assigned by the courts 5 or 10 years from now is going to be.

It is a lot easier for them to forecast where it will be in a year or two or three, and this change in insurance forms is going to help them do that.

Mr. ANTHONY. Any of you want to answer?

Mr. OWENS. Sure.

The insurance industry can do things to help itself and improve, and I hope they will learn from the experiences they have had and do that.

We certainly learn from things in Rohm & Haas. We make mistakes, but we learn from them and then do better.

Mr. ANTHONY. Your own industry is in the process of trying to work together with environmental groups to come together with a better way to get new agricultural chemicals marketed. So you can have a better way of knowing what your risk and exposure is.

Mr. OWENS. That is right.

Mr. ANTHONY. I guess it dismays me a little bit for you to come in here representing a large company as you do, and only laying 10 percent of the blame at the foot of the insurance companies.

I have got them assessed at least at 20 percent and not 10 percent.

Mr. OWENS. I just don't feel that the insurance industry itself is the fundamental cause of the problem or the area of the problem that cries most for attention.

However, they did screw up a few things in the last couple years, and I agree with that.

Mr. ANTHONY. Don't take me wrong. I was just trying to pick on you a little bit. You were the last panel, and I didn't want you to go home finding out that we were sound asleep.

Chairman PICKLE. Mr. Owens, did I understand you to say a minute ago that the insurance premiums involved approximately 30 percent of the product? That is, it almost costs as much for the insurance as for the manufacture of the product?

Mr. OWENS. That was a statement I made with respect to my background in the general aviation industry which ended in 1974.

However, last week I talked with some friends still in the industry and with the General Aviation Manufacturers Association, and right now in that industry product liability insurance is costing 25 to 30 cents per dollar of sales, maybe even a little bit more because of some of the production line shutdowns in the last few weeks.

Of every sales dollar, 30 cents goes to pay for the product liability insurance claim now. The direct labor cost is lower.

But this is a number that really you would be better served by getting from Mr. Stimpson of the General Aviation Manufacturers Association who testified on the last panel, however, I feel pretty confident about my figure.

Chairman PICKLE. I don't question that. I am saying if that is a fact, then it is an admission that product liability is a tremendous factor in the general aviation field and also a tremendous factor with other groups.

Mr. OWENS. It certainly is. I think that I can infer from what he said that Mr. Stimpson would probably agree with me that his primary concern for reform would be with the tort law, not necessarily with the regulation of the insurance industry.

Chairman PICKLE. Well, I don't know whether his testimony indicated that fact, but we will check that.

We are not drawing any conclusion that any one segment of this problem is the primary problem, but to say the insurance premiums are not a part of the problem is a misstatement.

We have to be honest about the overall problem, and it is a factor.

Mr. OWENS. It is the most immediate and obvious factor, no question about it, and it is of great concern to us. But we feel that at the bottom of things is the tort system and the need for tort reform, and that if the tort system were reformed, it would become easier for the underwriters to forecast their liability, and then the insurance rate and premium situation would stabilize.

Chairman PICKLE. Mr. Katz, what reason do your brokers give you for the increase in your premiums?

Mr. KATZ. They have no particular reason, Chairman Pickle.

There is no question of even redlining. We are not even talking about that, because we find the same prevailing situation both in the innercity congregations as well as the suburban congregations.

We find no pattern of discrimination between a congregation with a large congregational school and one that does not. It is just a general pattern we find.

I was impressed with the comments Mr. Anthony made. I brought with me today a display of 3 consecutive years' policies—liability policies for a day school, the Brandise day school in the Lawrence section of Long Island, a nice suburban area—no claims in a period of 3 years.

The 1983 premium stood at $2,093. The 1984 premium, same coverage, was at $4,000; 1985, the current year's premium, same coverage, $13,825.

No reflection of any claims. It is not like in workers' compensation that has a production reflection or a penalty for many situations that are adverse, none whatsoever.

In fact, two of these are the very same carrier, just tripled the policy premium. We don't understand it, and we do think there is something amiss in the insurance structure.

As Mr. Anthony pointed out, where were these promulgators of premiums for the past 7 years?

Chairman PICKLE. Have any of you sought relief by protesting these rates to your State insurance regulator?

Mr. KATZ. Sir, if the question is directed to me, we have no course of protesting. Either the company has a choice of writing the policy for you at the premium given or not, just as any insured, any institution has a right to shop around and seek any company that will write it.

In some cases, in the document that I presented to the committee, there is a situation where even Lloyd's of London just would not underwrite it.

Chairman PICKLE. Have either of you, for example, protested to your State insurance commission or the State regulator of insurance concerning the rates of these premiums and your objection to their increased costs?

Mr. POTTER. No, sir; I have not, but in North Carolina we just recently had a special session of the legislature, a 1-day session, dealing with the insurance problem, and they are investigating steps as to what can be done.

I do not know what the results of that meeting has been.

Mr. KATZ. Most respectfully, sir, that is what brought us here today. When we had occasion to meet with our representative, Mr. Charles Rangel, we brought this to his attention, and he was the one who was instrumental in giving us this opportunity to come before you and cite such a situation.

Chairman PICKLE. I am glad Congressman Rangel did mention this to us, because he is very concerned, and a very caring person.

Throughout this country we have a significant insurance problem. The committee is not trying to pass judgment on any one aspect of it, but simply trying to get as many facts on the record as we can.

I don't know that we will have another hearing on this problem until we see what direction we will go.

We have received several requests for more testimony. This is a problem common to every business, every professional organization, a problem for the tort system, the insurance companies, and the local people.

It is the No. 1 economic problem facing American business today, and we are going to try to address it as quickly as we can, because it is of an epidemic nature.

Well, we thank you very much. Your testimony has been very helpful.

The committee will stand adjourned.

[Whereupon, at 1:30 p.m., the subcommittee adjourned, to reconvene at 9 a.m., Monday, April 28, 1986.]

COSTS AND AVAILABILITY OF LIABILITY INSURANCE

MONDAY, APRIL 28, 1986

House of Representatives,
Committee on Ways and Means,
Subcommittee on Oversight,
Washington, DC.

The subcommittee met, pursuant to call, at 9 a.m., in room 1100, Longworth House Office Building, Hon. J.J. Pickle (chairman of the subcommittee) presiding.

Chairman Pickle. We will ask the subcommittee to come to order, and we will proceed.

Today, the Subcommittee on Oversight will conduct its fourth day of hearings on liability insurance. Specifically, we will discuss the appropriateness of recent liability insurance premium rate increases and insurance industry pricing policies.

We will receive testimony this morning from two invited witnesses: the U.S. General Accounting Office, GAO; and the Insurance Services Office, Inc. [ISO]. Both witnesses have gathered much data on the insurance industry and the current insurance crisis. Hopefully, their analyses and comments will shed light on the basic questions before this subcommittee that remain unanswered.

These questions are:

One, was it appropriate for insurance premium rates to increase as they did in 1984 and 1985?

Two, is the insurance industry in a bad financial state?

Three, where is the crisis in the insurance industry? Does it pervade all insurance lines or only certain areas—medical malpractice and commercial general liability?

Four, exactly how will various tort reform measures translate into lower insurance rates and expanded coverage?

I look forward to their testimony. I am particularly interested in hearing from ISO, since the insurance industry witnesses said ISO has the answers; that is, to questions we had asked at previous hearings.

In addition, let me note two issues that concern me. First, this subcommittee will soon complete the most comprehensive congressional review ever undertaken to determine why insurance rates have skyrocketed and who is affected. Unfortunately, no one agrees, or very few, on why the insurance crisis exists, who is at fault, or what the solutions are. Everyone points their finger at the person across the table. While the causes and solutions are not simple, something must be done. The problem will not solve itself.

I will continue to contact key committee chairmen and the Speaker to urge the creation of a multijurisdictional task force to coordinate our efforts to deal with the insurance crisis. It is important that Federal and State legislators get together and sort out exactly what needs to be done. There has been enough finger-pointing and recommending as to what other groups should be doing.

Second, earlier this month the President announced that he wholeheartedly supports the report of the administration's tort reform policy working group. The working group made various recommendations on how the judicial process and tort laws should be changed. Their report implied that major tort reform changes will solve or dramatically improve this country's insurance availability and cost crisis.

The hours of testimony this subcommittee has received to date has not proved that changes in the tort laws alone would result in any reduction in insurance premium rates or expansion of coverage. The administration's report specifically states that this issue was not fully considered by the working group. While tort reform may be necessary on its own merit—and I do support some tort law changes—I think the insurance industry does a disservice to the public by claiming their insurance crisis is really a lawsuit crisis. It looks like the administration has bought the insurance industry's strategy—hook, line, and sinker.

I do not believe it is enough to just say we need tort reform, because we do need some tort reform. I have concluded that today's insurance crisis requires a four-pronged approach. Any solution must include consideration of, one, some minimum Federal rules, such as expanding self-insurance; two, tighter State administrative and regulatory rules to ensure that consumers' concerns in the various States are addressed; three, a more responsive insurance industry, including full disclosure of insurance profits, losses, and pricing strategies; as well as, four, changes in the tort law and judicial process.

We will only make headway with the insurance crisis when the Federal Government, the States, the insurance industry, and the lawyers and judges participate in a four-pronged solution.

Before I begin, I should mention that this hearing will run until 11 a.m. At that time, the subcommittee will begin a second hearing to discuss the IRS's actions with regard to the tax-exempt status of private schools.

Does any member have any preliminary statement?

Mr. THOMAS. If we can get the Federal Government, the States, and the trial lawyers working together in the same direction, we can solve a whole lot more problems than just this one. So, I look forward to our effort.

Chairman PICKLE. Our first witness would be Mr. Johnny C. Finch, Senior Associate Director of the General Government Division of the General Accounting Office, GAO.

Mr. Finch.

STATEMENT OF JOHNNY C. FINCH, SENIOR ASSOCIATE DIRECTOR, GENERAL GOVERNMENT DIVISION, U.S. GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY NATWAR M. GANDHI, GROUP DIRECTOR

Mr. FINCH. Good morning, Mr. Chairman.

Before I begin, let me introduce my companion at the table, Dr. Natwar Gandhi. Dr. Gandhi is GAO's Group Director responsible for all the work we do in the area of tax policy. He has led, in fact, all of the work GAO has done that relates to the insurance industry.

I have a prepared statement, Mr. Chairman. I will follow it fairly closely, but I would like permission to submit it for the record.

Chairman PICKLE. When you depart from it, or when you come back to it, if you will point out where you are so we can follow you, Mr. Finch.

Mr. FINCH. Mr. Chairman and members of the subcommittee, we are pleased to appear before the subcommittee again to assist it in its deliberations on the subject of the insurance industry. At your request, we will address our remarks today to, one, the property/casualty industry's pricing strategies, particularly as they are affected by cash flow underwriting; two, industry profitability; three, the cyclical nature of that profitability; four, the financial outlook for the industry; and five, the current difficulties in the property/casualty industry, specifically as they relate to the medical malpractice and general liability insurance lines.

In addressing these issues, we will make the following points. Property/casualty companies have used a pricing strategy which sacrificed underwriting profit margins in order to generate cash for investment purposes. As a result of this strategy, the property/casualty industry has made, depending upon whose estimates are used, between $50 billion and $75 billion in net gains over the last 10 years. Furthermore, like many other businesses, property/casualty underwriting is subject to profitability cycles. While underwriting losses have mounted since 1980, estimated data for 1985 indicates that the underwriting cycle has turned and is now moving in a positive direction. Indeed, the industry itself is projecting substantial net gains over the next 5 years.

The current difficulties in liability insurance are found principally in certain liability insurance lines. Two lines frequently mentioned by the media within a crisis context are general liability and medical malpractice. These lines, however, represent a small portion, less than 10 percent, of the total property/casualty business. Furthermore, as compared to some reported premium increases, our computations show that, with smaller increases in earned premium revenues, these lines could break even.

I will now discuss these points in greater detail. In doing so, I will explain the sources of our data and the scope of our work.

First, some information on pricing strategies. A property/casualty company derives its income from two principal areas: underwriting gains, which are the excess of premiums over claims and expenses; and investment gains. Because of investment gains, a property/casualty company can have net income even though its premium revenues alone are not large enough to cover claims and expenses.

Thus, the ability to offset underwriting losses with investment income plays an important role in a company's pricing strategy—that is, the amount it charges for the insurance that it offers. For a number of years, many companies have employed a pricing strategy known as cash flow underwriting. Basically, companies have been willing to accept lower premiums for certain insurance lines in order to encourage sales and obtain funds for investment. In essence, the strategy has been to sacrifice underwriting gains for investment gains. For example, in 1984, claims, expenses, and policyholder dividends exceeded premium revenues by almost 18 percent.

The companies, however, have taken this risk because they expected to make up the premium shortfall through investment income. Through the increased volume of premiums resulting from this pricing approach, companies were able to generate a larger amount of net cash-flow which they could then invest to earn additional investment income. For instance, over the 5-year period 1980 to 1984, when the industry's claims and expenses exceeded premiums by about 9 percent, its underwriting loss was about $45 billion. Even so, the industry had $82 billion in investment gain which, when offset against its underwriting losses, resulted in a net gain of about $37 billion. The investment gain was made possible, at least in part, by the industry's pricing strategy which generated about $66 billion in net cash-flow. The industry was then able to invest these funds at favorable rates.

From 1975 to 1983, investment gains, in the aggregate, exceeded underwriting losses by a fairly wide margin. However, this situation changed in 1984 when underwriting losses for the industry were $19.4 billion while investment gains were $17.9 billion. Reacting to this result, some companies have sharply raised premiums.

We developed a financial overview of the property/casualty insurance industry using financial data for the 10-year period 1976 through 1985. We obtained the 1976-84 data from "Best's Aggregates and Averages," and the 1985 data from "Best's Insurance Management Reports," dated December 30, 1985. Basically, Mr. Chairman, the source of our data is data publicly available and data that has been reported by the insurance industry. The 1985 data were estimated by Best's since final 1985 operating results were not, and are still not, available. While Best's reports omit figures for many small or new companies, we believe that the data are representative of the overall financial results of the property/casualty industry.

In the table now before you, Mr. Chairman, we show sources of property/casualty income broken out by underwriting gains, and total gains. This table clearly illustrates the results of the industry's pricing strategy to obtain investment income at the expense of underwriting income. While property/casualty companies had about $65 billion in underwriting losses, they also earned about $140 billion from their investments during this 10-year period. Overall, the industry had a net gain of about $75 billion.

We would like to make two points about our figures which may differentiate them from figures developed by others. First, the investment gains include net investment income and both realized and unrealized capital gains. We recognize that unrealized gains are just that, unrealized; and therefore, are subject to investment risks which could result in lower or higher amounts. However, we have chosen to include unrealized gains in our figure because it is within a company's control to manage its investment portfolio so as to realize these gains while the investments are profitable.

Second, the underwriting losses do not reflect policyholder dividends. We consider these dividends to be voluntary, not mandatory, distributions by the companies. Since the companies are not required to make these distributions, we have chosen to exclude them from our underwriting loss figure.

Even if we adjusted our figures to exclude unrealized gains and to include policyholder dividends—this is the approach used by the industry for its calculations—the industry's net gain for this 10-year period would still be $51 billion. In either case, it is within management's discretion to realize investment gains or to not pay policyholders' dividends.

CYCLICAL NATURE OF INDUSTRY PROFITABILITY

While it is important to look at the figures for the most recent years, it should be noted that over the longer period the property/casualty industry has demonstrated profit and loss cycles. We believe that data covering longer periods give a more complete picture of the industry's profitability. Unlike most other industries, the property/casualty insurance industry is flexible with respect to capacity or supply. During profitable periods, insurance companies can increase their capacity, take varied and greater risks, and generally lower their premium rates to achieve a greater market share. Such actions result in price competition as other firms lower their prices to retain their market share. Price competition results in a change from favorable premium profit margins to unfavorable margins, resulting in the underwriting profit and loss cycles.

Attachments I and II illustrate the cyclical nature of the property/casualty industry profitability. Attachment I, which is now before you as a visual aid, Mr. Chairman, shows the year-by-year underwriting and investment results for the 12-year period from 1974 through 1985. Column 2 in that attachment, underwriting gains and losses, illustrates the cyclical nature of the industry. The earlier cycle bottomed out in 1975 with a $3.65 billion loss and peaked in 1978 with a $2.55 billion gain. Since 1980, underwriting losses have mounted again. However, estimates indicate that the loss cycle bottomed out in 1985 and that the cycle has now turned upward. Attachment II illustrates the cyclical nature of property/casualty stock companies over the past 40 years. For purposes of illustration, we used the combined ratio concept, a ratio of claims and expenses to premium income. The attachment reflects the industry's underwriting results and premium pricing strategy; it does not include investment results. As can be seen, stock companies have had several underwriting cycles since 1945.

The financial outlook for the industry appears favorable. From all indications, it appears that the trend toward larger underwriting losses has peaked. Available industry estimates show that over the next 5 years the industry expects substantial net gains. Our calculations, made from the industry estimates, indicate an expected net gain before taxes of more than $90 billion over the years 1986 to 1990.

Analysts of the industry also generally predict favorable industry prospects. For example, an August 1985 study by Salomon Bros. Inc.,[1] forecast that premiums written will grow at a 12-percent annual rate over the 1985 to 1989 period. The same study forecasts a 10-percent growth rate for incurred losses over the period. The study forecasts further that total industry profits will rise annually at a rate of 25 percent over the same period.

More recently, the "Best's Insurance Management Reports," dated December 30, 1985, estimated that net premiums written in 1985 would increase by 21 percent over the net premiums written in 1984.

PROBLEMS IN MEDICAL MALPRACTICE AND GENERAL LIABILITY LINES

Although the financial outlook for the industry as a whole appears favorable, the current difficulties in liability insurance are more pronounced in certain lines. Two insurance lines often mentioned in the context of high premiums and lack of availability are medical malpractice and general liability. General liability insurance includes coverage of items like day care centers, asbestos removal, and municipalities. The following examples are illustrative of some reported difficulties individuals and businesses have encountered recently:

In February, the Government's Interagency Tort Policy Working Group reported on a survey of day care providers which found that insurance policies had been canceled or not renewed for 40 percent of the respondents, and the majority of those with continuing coverage had experienced premium increases of between 200 and 300 percent.

In March, the American Medical Association testified before this subcommittee that malpractice insurance rates for obstetricians in Maryland increased by 130 percent last summer.

The March 24, 1986, issue of Time reported the story of one asbestos removal company whose policy increased in cost from $9,361 to over $450,000, an increase of almost 5,000 percent, despite never having been sued.

The medical malpractice and general liability lines, however, do not represent a major portion of the total property/casualty insurance business. Attachment III to my statement, which is now before you as a visual aid, Mr. Chairman, shows, for 1985, the relationship of these two lines to other property/casualty lines. The data were estimated by Best's, which reports on 27 insurance line categories. For our purposes, we have grouped certain lines into one category; for example, personal and commercial automobile liability is shown as automobile liability.

The figures in this attachment show that the medical malpractice and general liability lines represent a relatively small portion of the industry. Medical malpractice premiums accounted for less than 2 percent of all property/casualty premiums written for 1985, and general liability premiums accounted for less than 8 percent. However, underwriting losses attributable to these lines accounted for almost a quarter of all underwriting losses; medical malpractice being 5.6 percent and general liability being 18.3 percent. It should be noted, Mr. Chairman, that for certain companies that specialize in these liability lines, the proportion of the losses will likely be higher.

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[1] Salomon Brothers, Inc., "Property/Casualty Insurance Organizations, Five-year Review and Outlook," 1985 edition, August 1985.

Despite the relatively large proportion of underwriting losses that the medical malpractice and general liability lines represent, attachments IV and V show that in 1984 these two lines could have broken even with smaller increases in premium rates than the rate increases presently being reported in the media. Attachment IV, for example, shows that for the medical malpractice line, a premium rate increase of 20 percent would have put this line at a break-even point. Similarly, attachment V shows that for the general liability line, an approximate 30-percent increase in premium rates would have been sufficient to break even; 1984 is the most recent year for which we are able to make such estimates; the necessary data is not yet available for 1985.

In conclusion, Mr. Chairman, available financial information for a recent 10-year period indicates that the profitability of the property/casualty industry has been cyclical in nature. The data further indicate that over this period the industry has been generally profitable. The industry's profitability has been lower in recent years; however, the industry projects increasing premium volumes and more favorable prospects for the next few years. The data also show that while medical malpractice and general liability insurance have received considerable attention recently, they represent a relatively small portion of the industry overall. Finally, our calculations show that, for 1984, these lines could have broken even with smaller increases in premium rates than some premium rate increases currently being reported in the media.

That concludes my statement, Mr. Chairman. We would be pleased to respond to questions.

[The attachments to Mr. Finch's statement follow:]

UNDERWRITING GAINS, INVESTMENT GAINS, COMBINED UNDERWRITING AND INVESTMENT GAINS: ALL COMPANIES -- CONSOLIDATED BASIS[a]

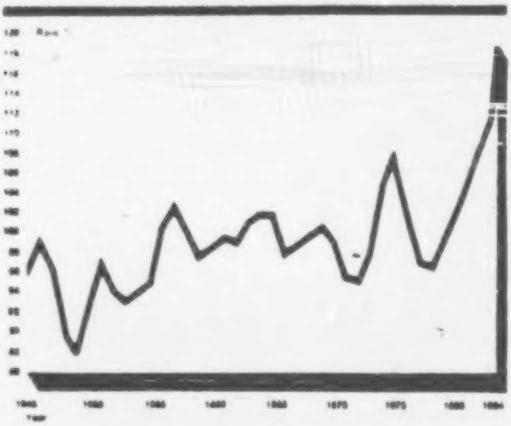
YEARLY 1974-1985

($ in millions)

Year	Underwriting gains/(losses)	Investment gains/(losses)	Total
1974	(1,974)	(2,443)	(4,417)
1975	(3,653)	7,009	3,356
1976	(1,726)	7,173	5,447
1977	1,926	5,063	6,989
1978	2,548	7,758	10,306
1979	24	11,610	11,634
1980	(1,712)	15,870	14,158
1981	(4,464)	10,858	6,394
1982	(8,303)	18,387	10,084
1983	(11,088)	19,441	8,353
1984	(19,379)	17,875	(1,504)
1985 Est.	(23,100)	26,200	3,100

[a] Consolidated totals eliminate double counting by excluding intercompany transactions between parent and subsidiary companies.

Combined Underwriting Ratios for Property/Casualty Stock Companies for the Years 1945-84[a]



Year	Ratio %	Year	Ratio %
1945	95.8	1965	101.9
1946	98.8	1966	98.1
1947	96.3	1967	98.9
1948	91.2	1968	100.0
1949	87.6	1969	100.6
1950	93.0	1970	99.3
1951	97.1	1971	95.8
1952	94.4	1972	95.4
1953	93.1	1973	98.2
1954	93.6	1974	105.0
1955	94.9	1975	107.5
1956	100.5	1976	102.0
1957	102.9	1977	97.0
1958	100.0	1978	96.6
1959	97.8	1979	99.6
1960	98.4	1980	102.4
1961	99.4	1981	104.9
1962	99.0	1982	108.7
1963	101.0	1983	111.8
1964	101.9	1984	119.0

[a] A combined ratio is a ratio of claims and expenses to premium income. Ratios below 100 represent underwriting gains and ratios above 100 represent losses.

Net Premiums Written and Underwriting Gains/Losses Estimated for All Insurance Lines for 1985 ($ in billions)

Selected long-tailed insurance lines[a]	Net premiums written	Premiums as a percent of all lines	Underwriting gains/(losses) after dividends	Underwriting gains/(losses) as a percent of all lines
Automobile liability	$35.7	25.1%	($7.3)	29.0%
Workers compensation	16.8	11.8	(3.7)	14.7
General liability	11.1	7.8	(4.6)	18.3
Medical malpractice	2.6	1.8	(1.4)	5.6
Subtotal	66.2	46.5	(17.0)	67.6
Selected short-tailed insurance lines[a]				
Automobile physical damage	24.9	17.5	(0.3)	1.2
Homeowners multiple peril	15.0	10.5	(1.8)	7.1
Commercial multiple peril	11.7	8.2	(3.0)	11.9
Subtotal	51.6	36.2	(5.1)	20.2
All others[b]	24.5	17.2	(3.1)	12.3
Total all lines	$142.3	100%[c]	($25.2)	100%[c]

[a] Long-tailed insurance lines are lines characterized by third-party involvement (an injured party other than the insured) and by settlements that will occur in an unknown future time period. Short-tailed lines, on the other hand, typically involve only two parties (the insurer and the insured) and settlements that will take place within a relatively short time frame (generally a year or two) following a claim.

[b] Includes such long-tailed lines as reinsurance and group accident and health, as well as such short-tailed lines as burglary and theft, and aircraft.

[c] Does not add due to rounding.

ATTACHMENT IV ATTACHMENT IV

Break Even Analysis for the Medical Malpractice Line in 1984
($ in millions)

Computation of Additional Earned Premiums Needed to Break Even:

Premiums earned	$1,707	
Net investment gains[a]	750	
Total Revenues		$2,457
Less:		
Net losses incurred	$1,913	
Expenses and dividends	868	
Total Outlays		2,781
Net income/(loss) before taxes		($323)[b]
Sales commissions on additional premiums ($323 / (1-.052) - $323)[c]		18
Additional earned premiums needed to break even before commission		$341
Percent additional earned premiums needed to break even (($341 / $1,707) x 100)		20.0%

[a] Does not include unrealized gains.

[b] Does not add due to rounding.

[c] Commissions paid on this line averaged 5.2 percent of premiums written.

ATTACHMENT V ATTACHMENT V

Break Even Analysis for the General Liability Line in 1984 ($ in millions)

Premiums earned	$6,251	
Net investment gains[a]	1,665	
Total Revenues		$7,916
Less:		
Net losses incurred	$5,456	
Expenses and dividends	4,100	
Total Outlays		9,556
Net income/(loss) before taxes		($1,640)
Computation of Additional Earned Premiums Needed to Break Even:		
Sales commissions on additional premiums ($1,640 / (1-.121) - $1,640)[b]		226
Additional earned premiums, needed to break even after commission		$1,866
Percent additional earned premiums needed to break even (($1,866 / $6,251) x 100)		29.8%

[a] Does not include unrealized gains.

[b] Commissions paid in this line averaged 12.1 percent of premiums written.

Chairman PICKLE. Mr. Finch, we thank you. This is an interesting and important testimony that you have given us.

Let me ask you, first, in the study that you have made for the committee, for the Congress, you state that you use as your source information gained from Best's insurance data collection system.

Is this the system that is used similarly by ISO and other organizations?

Mr. FINCH. This represents data reported by the industry, Mr. Chairman.

Chairman PICKLE. Is there any question about the authenticity? Should we have any argument about the source of the data? Is your data the same as the insurance companies use?

Mr. GANDHI. Yes, sir.

Chairman PICKLE. If there is a difference in your analysis as against the ISO, it is on an individual basis—the analysis—rather than any disagreement on the basic facts.

Mr. GANDHI. That is correct, sir. The basic data is supplied by the individual companies to the various State departments of insurance in a uniform statement, and from there all the data is collected and culled by Best, as well as ISO.

Chairman PICKLE. Mr. Finch or Dr. Gandhi, in your analysis, did GAO personnel have actuaries in making this analysis?

Mr. GANDHI. Yes, sir.

Chairman PICKLE. Did any of them have actuarial insurance backgrounds?

Mr. GANDHI. Absolutely; very distinguished experience of 50 years.

Chairman PICKLE. For our committee's information, we would like to have the names and background of the individuals with their titles and years of experience.

Mr. GANDHI. We will supply that.

Chairman PICKLE. I want to see what they know about the insurance industry or what background they have. That would be fine.

[The information follows:]

GAO

United States
General Accounting Office
Washington, D.C. 20548

General Government Division

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Ways and Means
Subcommittee on Oversight

The Honorable J.J. Pickle
Chairman, Subcommittee on Oversight
Committee on Ways and Means
House of Representatives

Dear Mr. Chairman:

We recently testified before your Subcommittee regarding the profitability of the property/casualty insurance industry. During our testimony, you requested that we provide you with (1) the names and qualifications of the principal GAO staff persons responsible for the analysis in our testimony and (2) some of the relevant factors that should be considered in evaluating the financial condition of the property/casualty industry. Our responses are attached.

Sincerely yours,

Johnny C. Finch

Johnny C. Finch
Senior Associate Director

GENERAL ACCOUNTING OFFICE STAFF PRINCIPALLY RESPONSIBLE FOR THE ANALYSIS PRESENTED IN APRIL 28, 1986, TESTIMONY

Dr. Natwar M. Gandhi:

As Group Director for Tax Policy, Dr. Gandhi's responsibilities include GAO's work on the taxation of financial intermediaries, including insurance companies and banks. Dr. Gandhi regularly represents GAO by presenting briefings and testimony to the tax-writing and other congressional committees. A well-recognized authority on the taxation of the insurance industry, he has addressed the Hartford Institute on Insurance Taxation, other insurance industry conferences, and meetings on tax issues.

Dr. Gandhi is a graduate of the University of Bombay (Bombay, India) from which he earned an LL.B. degree in 1964 and Louisiana State University (Baton Rouge, Louisiana) from which he earned a Ph.D. in Accounting in 1974. Dr. Gandhi has taught at several universities, including the University of Pittsburgh where he was on the faculty of the Graduate School of Business. He has served as a consultant to business, including IBM and Jones & Laughlin Steel. Currently, in addition to his work at GAO, he teaches at the University of Maryland, College of Business and Management, as an adjunct professor. Dr. Gandhi has published numerous papers in professional journals on accounting and taxation matters.

Mr. William Simpson:

Mr. Simpson has over 50 years of distinguished experience as an actuary. A 1930 graduate of Mount Allison University in New Brunswick, Canada, Mr. Simpson became a Fellow in the Society of Actuaries in 1945. Between 1930 and 1942, Mr. Simpson was employed as an actuary with the Sun Life Insurance Company of Montreal. From 1942 to 1979, Mr. Simpson worked for the Acacia Mutual Life Insurance Company in Washington, D.C. In 1979, he retired as Senior Vice President and Chief Actuary. Since 1980, Mr. Simpson has worked for GAO in various capacities in the area of insurance taxation.

FACTORS WHICH SHOULD BE CONSIDERED IN EVALUATING THE PROFITABILITY OF THE PROPERTY/CASUALTY INDUSTRY

There are several basic factors which should be considered when evaluating the profitability of the property/casualty industry. First, the underwriting portion of the property/casualty industry has been cyclical. That is, there have been periods of underwriting profits followed by periods of declining underwriting profits and even underwriting losses before the cycle has turned and repeated itself. Essentially, these cycles have been the result of the industry's competitive nature.

Another factor to be considered is that insurance underwriting comprises only one part of the profitability picture. Investment comprises a second part. As noted in our testimony, investment gains have far exceeded the industry's underwriting results over the past 10 years. Indeed, investment expectations have played a large role in the prices the industry has been willing to establish for writing insurance (cash flow underwriting). In fact, the revenues acquired from some of the "long-tailed" insurance lines which have been frequently mentioned by the media in a crisis context, such as medical malpractice and general liability, generate more investment income since their revenues stay in the industry longer. (These are called "long-tailed" insurance lines because the claims may not be settled for many years.) Thus, in any evaluation of the property/casualty industry's profitability, both the underwriting and investment portions of the industry's financial activities need to be assessed.

An additional factor that should be considered in assessing the industry's profitability is its "rate of return on net worth." Rate of return on net worth is a common measure used by investors in making investment decisions. The rate of return investors expect to achieve when they commit their funds to the property/casualty insurance industry will depend on how they assess the risk in the industry compared to that in other potential investment opportunities. Data published by the Insurance Information Institute for the 10-year period 1975-1984 show that the average rate of return for the property/casualty industry was 10.9 percent. The rates of return during this same period for other industry groups included: banks, 12.6 percent; transportation, 10.6 percent; and utilities, 11.9 percent. The rate for all industry groups combined was 13.2 percent. It should be noted that, in recent years, the rate of return for the property/casualty industry, as compared to other industries, has declined.

The above factors primarily provide an historical picture of industry profitability. Thus, another important factor to consider is the future profitability of the industry. As noted in our testimony, it appears that the underwriting cycle has bottomed out and is beginning to move in a positive direction. In fact, the industry is predicting a more profitable future, in large measure as a result of actions it has taken on the underwriting side of its activities.

Chairman Pickle. Now, one of the concerns we have, since the primary report has been made now about tort reform, is a question of whether changes in the tort system would result in lower insurance premiums.

Can you give me any analysis or any statement as to whether, if these tort reforms were made, would it mean lower premiums; and to what extent would it mean lower premiums?

Mr. Finch. No, sir; we cannot. We looked at the financial data that had been reported by the industry, and one piece of information, or pieces of information that we did not have access to and have not looked at relates to settlement of individual claims, settlements out of court, those kinds of things. So, we can't really respond to the question that you have asked in terms of that.

Also, it would seem that—it would still be up to the industry, without some form of regulation being imposed, as to what premiums they might choose to charge, even if you had tort reform.

Chairman Pickle. Your answer is that even if you had tort reform, with the limitations as recommended by that working group and as endorsed by the President, you are not certain that it wouldn't result in any lower premium rates or any material lowering?

Mr. Finch. That is correct, sir. I am not certain that it would. I think it would still be up to the industry to decide the premiums it wanted to charge, unless there were some form of regulation.

Chairman Pickle. Dr. Gandhi, do you agree with that?

Mr. Gandhi. Yes, sir.

Chairman Pickle. Now, what actually is the issue here—the insurance companies claim that they have sustained great losses and, thus, it is necessary to increase their premiums from 10, 20 percent, up to as much as 5,000 percent in the asbestos industry. But, ever excluding the extreme cases, they said it is still necessary to raise premimums.

You testified that even considering the losses they have had, they still have made a profit—have had a profitable picture for the last 10 years roughly.

What is the period that you had?

Mr. Finch. Ten-year period, sir.

Chairman Pickle. Ten-year period.

Why would there be, then, a necessity for increasing premiums that much? I presume that is a question I should ask the insurance companies.

Would you state your opinion of it?

Mr. Finch. We will take a shot, sure.

The industry did, in 1984, have a loss year. Up until that point, even though they had an overall loss year, they had losses in underwriting results but not in terms of overall gains.

In 1984, our calculations show that in terms of underwriting results, they did in fact incur a loss, and that they would have needed to increase their premiums in order to reach a breakeven point. So, from that standpoint, I guess you could say that some premium increases might be warranted based upon the 1984 results. However, using the industry's own projections, they are projecting favorable financial prospects for the next 5 to 6 years, in fact, to the tune of some $90 billion over that period.

One would assume that those projections would include their actuarial estimates of the losses they expect to incur. So, given that, I think you have an excellent question, sir, to pose to the insurance industry.

Chairman PICKLE. Mr. Finch, in my opening statement I made the observation that it seemed to me it was more than just tort reform, although that would be a factor. I mentioned the probability of some Federal rules or standards along with State regulations, as well as changes within the insurance industry.

Would you say that is a reasonable approach? Do you have any specific suggestion what the Congress ought to do to try to reduce the difficulty we are having now in the insurance industry.

Mr. FINCH. I think your suggestion is an excellent starting point. I think some of the figures we have come up with don't necessarily jump out and give you a solution. What they do, I think, is point to the need for further inquiry by the Congress; in particular, by this subcommittee.

In that regard, I think some of the issues that you may wish to pursue, particularly with the industry, are issues about their projections and the line-by-line results of their projections. We know very little about their methodology in making their projections in the aggregate or line by line.

I think also some issues that the subcommittee may wish to pursue are the amounts of settlements in terms——

Chairman PICKLE. I beg your pardon?

Mr. FINCH. The amounts of settlements. In other words, just exactly how much are the claims that they actually had to pay? Because I know a number of claims have been settled out of court. So, the court award may not necessarily represent the actual cash outlay on the part of the industry. Those are all pieces of information that I think the subcommittee would find very useful.

Chairman PICKLE. In your study of the ISO on this whole question, as a question for the Congress, have you been in touch with the ISO regarding your study and your analysis? Have they been talking with you or vice versa?

Mr. GANDHI.Yes, sir.

Chairman PICKLE. So, there is a clear difference in your conclusions?

Mr. GANDHI. Yes, sir.

Chairman PICKLE. ISO indicates that the losses of the P and C companies really should not be compared with losses of, say, Fortune 500's; that they have a different situation with respect, I guess, to the net worth of these companies.

Is that a valid observation? There must be some big differences between your analysis and their analysis. What is the big difference?

Mr. FINCH. I think one of the big differences of our analysis, sir, is that we are looking at the data that has been reported for the past couple of years and analyzing it from a financial standpoint. What we don't have is information that I mentioned earlier about the actual amount of claims that the industry is having to pay and how they go about making their projections.

I think that may be the difference between where we are coming from and where the industry is coming from.

Chairman PICKLE. The Chair is going to yield to some of the other Members, and then I will have other questions. I want to stay within the 5-minute limitation as best we can.

The Chair will yield to Mr. McGrath.

Mr. McGRATH. Thank you, Mr. Chairman.

I sort of gleaned from your testimony that, at least on the numbers, you don't consider that to be as large a problem as reported in the papers or as we see in terms of our mail.

Am I correct in that assumption?

Mr. FINCH. I guess our calculations would show, sir, that some of the premium increases that have been reported in the media seem a bit large based upon the aggregate look at the industry and the breakeven calculations that we made, which were based on industry reported data.

Mr. McGRATH. I think we as a committee, and perhaps this level of government, have been a little late in investigating this particular crisis or at least the appearance of a crisis. As I understand it, there are at least 34 States that have some type of liability insurance legislation either enacted or in the process of being enacted.

Have you been able to take a look at some of that legislation and determine whether or not it is sufficient to handle some of the problems that we hear about, or you have looked at?

Mr. FINCH. No, sir; we haven't really looked at the provisions of the individual States.

Mr. McGRATH. You answered the chairman's question regarding tort reform by responding that you do not know whether or not tort reform would reduce the amount of premiums paid.

I would surmise from that that the issues within tort reform are structured settlements as well as limitations on attorneys' fees and amounts paid for pain and suffering.

You wouldn't have any information as to whether any of these components of tort reform would have any kind of effect on premium stabilization or reduction, would you?

Mr. FINCH. No, sir; we would not. Again, that is one of the missing pieces of information in terms of the costs actually being incurred by the industry and the claims that they are settling for.

Mr. McGRATH. Whose arguments and numbers, then, would be used by the New York State Legislature, for example, my home State to prepare the insurance crisis alleviation bill, they are going to do this year? Where does the New York State Legislature get information that presumably we don't have?

Mr. GANDHI. As you know, sir, they had hearings throughout the State. We went and testified before them, too, and explained the numbers that we have and how we got those numbers.

Mr. McGRATH. That is an important point. You testified before that commission, gave them numbers, and yet they are coming up with a bill that has an important tort reform component.

Are they doing that, based on your testimony, and perhaps the testimony of others? Whose testimony are they using in preparing their insurance bill, including its tort reform component?

Mr. FINCH. I am not sure I can respond to that, sir. I think that the question can only be answered by them.

Mr. McGRATH. It gives me pause to reflect as to the nature of your numbers. If, in another legislative body, the same numbers by the same people were given, and yet discarded to some respect, because that body is going ahead with a liability insurance package—which has a tough tort reform aspect to it—why are they doing that, and whose numbers are they believing if your numbers aren't being used?

Mr. GANDHI. I think we would like to address this question this way: that our numbers, as they are put forward here, as elsewhere, as Mr. Finch pointed out, are all derived from publicly available data. The question of income measurement, as to what is income gain, depends upon assumptions you make as to what goes in and what does not go into that.

As we have identified here and as our differences with the ISO become clear that in the underwriting part of our operations we have excluded the policyholder dividends and in the investment income aspect of the business we have included the so-called unrealized gains, that is how we can explain the differences that exist between our numbers and the numbers provided by the industry.

But I think the important point we want to keep in mind is that we cannot look at just 1 or 2 years, 1984, 1985. If you look at those 2 years, obviously one would say yes, the increases are justified or that the industry appears to be in a very bad state of affairs. We have to accept the basic cyclical nature of the industry.

The chairman earlier asked us about the comparison between the Fortune 500 numbers. If you look over 10 years, the industry's rate of return on net worth is not appreciably lower than the Fortune 500 companies.

Mr. MCGRATH. So, what we have here is two ways of looking at the same numbers. One, you are looking in terms of the cyclical nature over a longer period of time; and two, a different interpretation of the numbers that exist.

Am I correct?

Mr. GANDHI. Yes, sir.

Mr. MCGRATH. Thank you, Mr. Chairman.

Chairman PICKLE. Mr. Anthony.

Mr. ANTHONY. Thank you, Mr. Chairman.

Welcome, Mr. Finch and Mr. Gandhi. In your testimony you talk about the 5-year projection for net gain, 1986 through 1990. I wrote down $90 billion.

Is that correct?

Mr. FINCH. Yes, sir.

Mr. ANTHONY. You indicated some of the investment brokerage houses had done an analytical study of the industry and they have made projections of 12 percent growth in gain over losses.

Is that——

Mr. FINCH. A 12-percent annual growth rate in premiums written versus a 10-percent growth rate in losses incurred. So really a 2-percent spread.

Mr. ANTHONY. A 2-percent spread of premium over losses?

Mr. FINCH. Exactly.

Mr. ANTHONY. This is what knocked my britches off when I heard this. They are projecting a 25-percent annual profit for the years 1986 through 1990?

Mr. FINCH. Yes.

Mr. ANTHONY. After all these problems, they are saying they are going to make a 25-percent annualized profit for the next 5 years?

Mr. FINCH. I should clarify that, sir. It is a 25-percent annual rate of increase in profits.

Mr. ANTHONY. My question is this: Are these projections based on the current tort system?

Mr. FINCH. Yes, sir.

Mr. ANTHONY. So, if we do have tort reform, you would expect those numbers to go up higher? Because the industry's testimony before this committee has been that although they cannot promise that the insurance rates will go down, at least they will stabilize; so that if they do stabilize with the insurance premiums coming in, it appears to me their net profits over the next 5 years, if they get tort reform this year, would have to go up.

Is that not logical?

Mr. MCGRATH. Will the gentleman yield?

The gentleman testifying has made the assertion in previous answers to similar questions that tort reform most probably would have no effect on increases in premium, or decreases.

Mr. GANDHI. As Mr. Finch pointed out earlier, it is difficult to make that connection between the tort reform and the industry's profitability.

Mr. ANTHONY. I understand that.

I guess what bothers me, with all of the projections—and we will have their witnesses coming up to see if they refute these 5-year annualized projections—what disturbs me is this: We have got small business people out there. 350 delegates in the State of Arkansas met. These are delegates that have been appointed to the White House Conference on Small Business. They have listed insurance costs and availability as their number one issue.

Small businesses who hope to have made a 25 percent profit on an annualized basis for the next 5 years are going to be paying 20 percent of those profits to the insurance company rather than keep it, or they are going to have to go bare. And this is what bothers me, especially if the current projections are based on the current legal tort system. I mean it seems like it shoots down the argument for tort reform.

Let me tell you what bothers me about tort reform. Here is the latest edition of Forbes, a widely read, respectable magazine. You get to looking in here on one of the editorial sections, and it has a big headline that talks about a case up in the Northeast. It says right here, another reason for tort reform, "Woman Wins $1 Million in Psychic Power Suit." This is reported from a Philadelphia March 28 UPI article.

Well, the truth of the matter is the jury held against this plaintiff on her claim for loss of psychic damage. In fact, over one-half of this million dollars is accrued interest on the judgment because interest in that State runs from the date of the lawsuit and not the date of the injury vested. That is one of the most misleading articles I have ever seen in a national public magazine.

Now, that has to be done for a real reason, and that is to scare the American public into believing that tort reform is the simple answer to this problem. And I think it is going to be up to the Congress and to people like you, Mr. Finch, to expose this as not correct.

In looking over ISO testimony, they report that year-end 1985 results show no significant improvements over 1984. Your testimony differs. And this is despite substantial premium increases.

Can you tell this subcommittee what evidence is there that this is incorrect or that the industry is climbing out of that 1984 downturn? How do we wade through the differences in your conclusion and their conclusion over the same data?

Mr. GANDHI. In 1985, by the industry's own accounting, there was a $2 billion after-tax profit. That was that industry's own accounting. So, it is indeed a substantial improvement over 1984. There was a loss in 1984.

Mr. ANTHONY. Why would their testimony differ?

Mr. GANDHI. It is difficult to say, sir.

Mr. ANTHONY. It is difficult to say, so we will ask them.

Mr. FINCH. In terms of the net gain that they have reported, comparing 1985 with 1984, in 1985 net premiums written increased by 21 percent over 1984. This is according to their figures. Net premiums earned increased 15 percent over 1984. And investment gains increased 47 percent over 1984. And those numbers indicate to me a turn.

Mr. ANTHONY. I have got a couple quick questions I would like to ask. We are going to be forced later on maybe to vote on some legislation. We are going to vote on that legislation. At least we ought to be on solid reasoning as to why we are voting on that legislation.

The industry is saying one thing. You, as our representative, have looked at the data, hopefully in a neutral manner, and have reported to us.

What are some appropriate relevant factors Members of Congress should consider in evaluating the financial condition of the insurance industry, and how do these following factors fit in: the profit levels, the net gains, net worth, stock market performance, surplus levels, reserves, underwriting losses, and investment income?

Mr. FINCH. Would you like us to——

Mr. ANTHONY. If you would like to respond, maybe later on, more fully to that question, because it is a very wide-ranging question—but I think it goes to the central core of the problem because you have the stocks out-performing the market. It is a bull market. Yet, you get different components and different answers in each one of these categories, and I think it is important for us to know how they all fit together and how we should take a look at each one in conjunction with the other.

It is an expansive question, and I think you could give a short answer today and a more detailed answer later on.

Mr. GANDHI. I would say this, to repeat what I said earlier, sir: That we have to look at the industry in a cyclical perspective. You just cannot look at the last 2 years. If you do that, then you really go into a different kind of approach.

So, one thing is sure: That one has to look over 10 years. Two, is that you cannot simply look at the underwriting side of the operations; you have to look as well at the investment side of the business, because the insurance business now is not merely underwriting but, equally, if not investment, financial aspect of the business.

And, too, all these questions about the probability of future losses, you have to keep in mind that the industry deals in the future. It is their business indeed to take risks. It is part of the deal. So, these things have to be kept in mind when we evaluate any of the industries' financial performance.

Mr. ANTHONY. I would like to congratulate you, Mr. Finch, for making one suggestion. And I would like to illustrate a case in point as to why I think you are right on target.

You say you feel there is need for further data projections by the industry on a line-by-line basis, finding out what their methodology is, and also what the amount of settlements are.

When the nonprofits came in and testified, I must tell you not only was I shocked but I was very disturbed about what I heard. Witness after witness came in and testified; and, Mr. Chairman, you will recall this one witness came in from your State of Texas, had over 50 years of premiums paid out, and not one single claim made.

So, my challenge was this: Go back to your insurance company and get the data, find out how many settlements had been made, how many jury verdicts had been paid out, and bring it to us so we can analyze that.

I was contacted last week by that witness. That witness said that their insurance company had refused to give them that information. I couldn't believe them. I just absolutely still cannot believe them.

My request then was for that witness to write me a letter, addressing it to the chairman, saying that they had made the attempt to the insurance company to get the information, but the insurance company had refused. And we would make a special request.

What I am hearing you say is, in order for us to really complete a detailed analysis and study, we need to get that information.

So, I guess publicly, Mr. Chairman, I am saying that we need to dig into this and get those settlements; otherwise, we are going to be absolutely brainwashed into thinking the only solution to this problem is tort reform.

You can't pick up a publication, you can't turn on a television set where they are not trying to brainwash America into thinking that is a simple solution to this problem. And we have found through 3½ days of hearings that it is much more complex than that.

And I think you have made a very, very valuable contribution today, Mr. Finch, in just making that as a future suggestion. I want to thank you for that.

Mr. Chairman, I hope we follow up on it.

Chairman PICKLE. Thank you.

The Chair would want to observe at this point this committee is not trying to pass judgment whether the premium increases are correct or incorrect, or whether the total profits and losses are as stated by the GAO or ISO. We are trying to get facts and figures and information. That is the purpose of the hearing.

Some of the questions sound to me as being rather negative, because we are getting frustrated.

Mr. Finch, Dr. Gandhi, either one of you, are we having difficulty getting facts and information from insurance companies, such as Mr. Anthony just made reference to, at this point? Are we getting full information from the insurance companies about losses?

Mr. Anthony. Would you yield for one point?

Chairman Pickle. Yes.

Mr. Anthony. Just a further analogy in conjunction with that same story I just told.

In working with some of the representatives of the American Trial Lawyers Association, they have told me that they have tried, through their organization, to obtain—tried to obtain the same data so they can make a valuable contribution to this record, and they have run into the same stone wall. For some reason, the data base has not been assembled in such a way it is easy to pick up; and, as a result, any company can say anything they want and we don't have any way to refute it. And I think that this is a big flaw in the data-gathering system, and we need to take a close look at it or, otherwise, we will end up making choices based on conjecture rather than on data.

Chairman Pickle. The Chair had asked the question, are we having difficulty getting full facts and information from the insurance industry?

Mr. Gandhi or Mr. Finch, do either one of you want to respond to that?

Mr. Finch. We have focused primarily on the data that has been reported by the industry companies, and that is the data that is the basis for our statement today.

Have we approached them specifically about——

Mr. Gandhi. No, sir.

Chairman Pickle. Mr. Anthony, I want you to give me a copy of the letter you requested from the witness.

Let me ask you, Dr. Gandhi, does the property and casualty insurance industry project further net gains or profits?

Mr. Gandhi. Sir, on the projections that you see, there are those of the profits.

Chairman Pickle. Are these profits based on the current tort system?

Mr. Gandhi. Yes, sir.

Chairman Pickle. So if there were changes in the tort system, that could make the profits even larger?

Mr. Gandhi. As Mr. Finch pointed out earlier, sir, it is difficult to establish any connection between the tort reform and industry's profitability, so it would be difficult for me to answer that question.

Chairman Pickle. It would seem to me it would be something that would make the profits even larger, if there were major changes in the tort system.

I had asked at the very beginning of my statement about what was the appropriateness of the rates and the factors that went into determining them. So I ask you, what are the appropriate and relevant factors that Congress should consider in evaluating the financial conditions of the insurance companies?

I want to ask you these questions, and you may respond to me in writing at a later point. We don't have time at this point.

I have asked you how these items fit into that general question: the profit levels, the net gains, net worth, stock market performance, service levels, reserves, underwriting losses, and income. We will submit those to you specifically in writing. I would like for you to know that.

[See response at p. 998.]

Chairman PICKLE. Now, what was the average premium rate increase in 1983, 1984, and 1985? What was the average premium rate increase?

Mr. GANDHI. At this time we have no information on average premium rate increases. However, the total written premiums increased about 10 percent a year over this period. But I cannot be entirely sure at this time.

Chairman PICKLE. How much?

Mr. GANDHI. Around 10 percent.

Chairman PICKLE. 110?

Mr. GANDHI. No, no; about 10 percent. But I cannot be entirely sure of that. I can provide that detail later, sir.

Chairman PICKLE. In response to this question, you can give us the answer in writing if you would. If that was approximately—your 10-percent figure, whatever it is—would occur in the following lines—that is, home owners, automobile, general liability, and that would include municipal, commercial, product, day care, medical—I would want you to give me the answer specifically as to how that relates to those particular areas.

You state that the rate increases of 20 or 30 percent for medical malpractice and general liability, that was really all that would be needed.

What do you think of increasing it to 100, 200, 300 percent, 500 percent? How would they justify charging up in that range of increase?

Mr. FINCH. Again, Mr. Chairman, the 20-percent breakeven point, 20-percent additional premiums for medical malpractice and the 30-percent additional premiums for general liability, we computed on the basis of the data that they had reported actually for 1984. Now, presumably their figures include their loss estimates for the future, but we don't know what projections they have made in terms of their future losses and how they are figuring that into their current premium increases.

Chairman PICKLE. I want you, before you leave, to tell me again why your analysis would indicate that you should have some premium increases up to 20 or 30 percent. What is the difference between your conclusion and the ISO's conclusion, as you see it?

You know generally their response has been in direct contradiction to what you are saying. How do you explain the difference between the way they analyze it and the way you analyze it? What is the basis for such a vast difference of opinion?

Mr. FINCH. A couple of things, Mr. Chairman, I think. One difference, which is a difference in the definition of "income," which will make a difference in the figures but not that great a difference, is what you include and exclude in income, and we have talked about that in terms of we have excluded the dividends, policyholder dividends, from the underwriting loss figures, and we have included unrealized gains into the investment gains figures.

The industry does the opposite. But there again, while that will make a difference, it doesn't make that great a difference overall.

I think one of the big differences is that we are looking at the industry in terms of a larger period of time, a 10-year period, and in some instances, as you note in one of the attachments to my statement—I forget which one it is; attachment II, I think, maybe—we went back and looked at the stock company performance since 1945 and brought it forward, and it does show definite cyclical trends. Given that, we think it might be erroneous to just look at 1 or 2 years' worth of performance data and make decisions on that. We think a longer period of data is more meaningful.

Chairman PICKLE. Mr. Finch, that will complete the questions for you gentlemen. We will ask you to wait. We want to have testimony now from ISO, and then it may be that together we will want to ask questions of both the GAO and of ISO.

Will you do that?

Mr. FINCH. Certainly, sir.

Chairman PICKLE. Thank you very much for your testimony.

Just a minute, Mr. Finch.

Mr. McGrath.

Mr. McGRATH. I have just one question.

You referred to cash flow underwriting, as being a way of reaping profits from investment income and offsetting insurance losses. Would you characterize that as a legitimate way of doing business for the insurance industry?

Mr. FINCH. Oh, I would be very hesitant to say it is illegitimate, sir.

Mr. McGRATH. Thank you.

Chairman PICKLE. Thank you, Mr. Finch and Dr. Gandhi.

Now the Chair would ask Ms. Mavis A. Walters, senior vice president of the Insurance Services Office—that is, the ISO—if she would come to the witness table now.

We are glad to have you here. We will ask you to proceed, and then we will have questions after that.

STATEMENT OF MAVIS A. WALTERS, SENIOR VICE PRESIDENT, INSURANCE SERVICES OFFICE, INC.

Ms. WALTERS. Thank you, Mr. Chairman.

I am Mavis A. Walters, senior vice president of the Insurance Services Office. I am a fellow of the Casualty Actuarial Society [CAS] and a member of the American Academy of Actuaries.

Insurance Services Office, Inc. [ISO] is a nonprofit corporation that makes available rating, statistical, actuarial, policy form and related services to any U.S. property/casualty insurer. We are not a trade association. We do not lobby, and we do not take positions on prospective legislation.

So, in that vein, I would like to make it abundantly clear that it is not my purpose this morning to talk about the lawsuit crisis or to discuss specific tort reform proposals. I have no special competence or expertise in those areas, and I understand you have had a great deal of testimony on that subject.

Rather, my testimony deals with the economics of the insurance business, the actuarial and financial considerations affecting the prices and profitability of property/casualty insurance.

We have provided a lengthy formal statement, Mr. Chairman. I am not going to read it. Instead, I would like to address some of the questions which you have posed.

In order to put into perspective the questions relating to recent price increases for property/casualty insurance, I believe it is incredibly important to understand and appreciate the financial condition of this industry today. It is clear from the discussion this morning there is still a great deal of confusion.

While much has been written about the recent financial distress, it is worthwhile to review some of the more important economic considerations. It is now beyond dispute that 1984 was the worst year to date for the property/casualty insurance. Net income after taxes fell to $1.3 billion, producing a return on net worth of only 1.7 percent.

The first chart here, Mr. Chairman, compares—the red line is the return on net worth for the property/casualty industry; the green line is the return on net worth for the Fortune 500. You can see from the period 1979 through 1984 the return for the PC industry has fallen increasingly below that of the Fortune 500.

The results for 1985, which unfortunately are not on the chart, don't show any significant improvement. Net income after taxes grew to $3.5 billion on a GAAP adjusted basis; that is, adjusted for generally accepted accounting principles. But the return on net worth was still only 3.8 percent.

Remember, the return on net worth for the Fortune 500 in 1984 was 13.6 percent, so for the PC industry, by that standard accepted measure of profitability, return on net worth—for PC insurers in 1984 it was 1.7 percent; in 1985, it was 3.8 percent.

Mr. GUARINI. May I just ask you, if I may interrupt here, is this based on the accounting principles where you have already deferred——

Ms. WALTERS. No; that is the point; that these have been adjusted for inter-industry comparisons which, should be made on the same accounting standards basis. So these figures and the returns on net worth that I cited reflect generally accepted accounting principles, not insurance statutory accounting. So that they are on a comparable basis.

Mr. GUARINI. Putting them on a comparable basis, you are still taking reserves for losses as you set this up?

Ms. WALTERS. That is correct.

Mr. GUARINI. This can be an enormous sum of money that you are not figuring in.

Ms. WALTERS. I disagree with that, and I would be happy to explain that later.

Mr. GUARINI. That is all right. At least I understand where you are coming from.

Ms. WALTERS. It adjusts for the prepayment of expenses and some other items that are a little different from statutory accounting versus GAAP accounting.

To understand why this overall profitability has been so low—yes, there have been positive net gains, but very, very low in comparison to other industries. To understand why it is so low, I think we have to look at the most important component of net after-tax income. It is the component that stock analysts look at, and the component that insurance managements look at, and that is the figure called pretax operating income. It represents the sum of underwriting income and all investment income—investment income, but not realized capital gains or unrealized capital gains.

This figure is important, this operating income is important, because it represents profit or loss from insurance operations, both on their underwriting and on the investment income they earn from those invested premium dollars. It tells us whether and to what extent insurers made money because they were in the insurance business.

As you well know, underwriting income, with the difference between premiums earned and claims expenses and policyholder dividends, has actually been an underwriting loss beginning in 1979. The second chart shows this very graphically.

The red figures represent the underwriting loss, and the green figures represent investment income. The underwriting losses have actually grown every year since 1979, reaching $21.5 billion in 1984 and $25 billion in 1985.

By the way, these underwriting losses didn't result from just the widespread insuring of so-called bad risks, as some have suggested. They resulted because insurance was provided at prices that were with hindsight too low.

Prior to 1984, however, the industry's investment income—that is, the interest and dividends received—was sufficient to offset underwriting losses in every single year except in 1975. So, in every year except 1975, we had positive operating profits. In 1975, a modest $300 million operating loss was experienced.

In 1984, a new record was set. You can see it on this chart, when the red overshadows the green. In 1984, underwriting losses exceeded investment income by $3.8 billion; that is, a $3.8 billion operating loss.

In 1985, another record operating loss was recorded, this time by over $5 billion. I think this point is worthy of emphasis. In 1984 and 1985, the property/casualty insurers lost money on the insurance business.

The only reason there was any positive net after-tax income in those 2 years was because of extraordinarily large amounts, unprecedented amounts, of realized capital gains and tax credits. If the property/casualty industry is to survive and grow over the long term, a reasonable and healthy level of profits must come from insurance operations.

Let's remember, this is why insurance companies are in the insurance business—to try and make money on the insurance business, not by selling off of assets and thus realizing capital gains.

Unfortunately, many people do not understand the critical need for current premium increases, some of which are quite large, particularly for commercial liability insurance coverages. I think there are two aspects to this and two explanations for it.

One is that past prices have simply been too low; and the second explanation is that losses have been increasing far beyond the level that any of us could have predicted several years ago. From 1979 through 1984, insurers provided coverage to commercial customers at very low premiums in recognition of the investment income which they could earn on those premium dollars. Now, while customers did benefit from low prices during those years, by the end of 1984 it became apparent that insurers had reduced prices far below the level needed to cover actual loss costs.

But there has also been an extraordinary growth in losses. In the past 5 years, growth in property/casualty losses has far exceeded the country's economic growth as measured by gross national product.

This first chart—it is a little small; I apologize for you not being able to see it too well—but this chart does show that during 1979 through 1985, gross national product grew by about 50 percent. That is the sort of orange line that is in the middle there, and you can see it increasing throughout that period.

Written premiums grew 34 percent. That is all line-written premiums. It is the second to bottom line there.

I apologize again. These colors aren't too vivid. But paid losses overall grew by 76 percent. That is the yellow line, overall paid losses.

But the increase in losses was not uniform for all lines of insurance. Commercial lines' paid losses grew 92 percent, which is the red line at the very top of the chart. And on the next chart you can see that commercial liability paid losses increased 130 percent during this period. Commercial liability paid losses are that yellow line which is going up.

Remember, this is when gross national product grew only 50 percent. But commercial liability paid losses increased 130 percent during this period.

The GNP is again that pink line. It is sort of in the middle there.

But, worst of all, general liability and medical malpractice, the red line at the very top of that chart, for those two lines paid losses have grown 167 percent over the 5-year period, more than triple GNP growth.

Now, while availability and affordability problems are certainly due in part to these past price reductions, a major contributor to the problems today have been the significant increases in losses.

It should also be emphasized that the large premium increases occurring now, particularly for the commercial liability lines, will not recoup past losses, will not make up for recent substandard profits. Insurers cannot get back money they have lost in the past 2 years. It is gone. Premium increases today are needed simply to bring today's insurance prices up to the level of losses expected to be paid under today's insurance policies.

Insurers want to be certain that the premium they charge on current insurance policies won't result in future losses, as has happened in the past two years.

While the dismal financial results of the property/casualty industry over the past 2 years are a historical fact, some have suggested that this distress was caused by insurers' own aggressive price competition over the past 6 or 7 years. Others assert that today's problems are solely a function of excesses or distortions in our civil justice system. I believe the truth lies somewhere inbetween.

In any event, insurers have not been sitting by during this period of time doing nothing. Rather, over the past 6 to 8 years we have been working diligently to design a new product, and we have introduced now a new, modernized, simplified commercial general liability policy form to respond to current marketplace needs. This new CGL Program offers a choice between two attractive alternative versions of a commercial general liability policy.

One, the occurrence version, provides coverage for bodily injury and policy damage incurred during the period; the other the claims-made version will provide coverage if the claim for damages for bodily injury or property damage is first made during the policy period. The only difference between the two versions is in the provision relating to what triggers coverage.

We expect that the availability of a claims made policy will increase the availability of insurance, particularly in those instances where occurrence coverage simply cannot be underwritten or priced accurately. And we believe it will allow insurers to price their products with greater assurance.

We certainly don't suggest that the CGL Program can or will solve all of the industry availability and affordability problems, but we are confident that it will be seen as a positive step taken by the industry in these difficult times.

Now I would like to just make a few comments about ratemaking and insurance prices. Some mistakenly believe that insurance rates are made or based on countrywide loss experience. That is not true. The fact is that insurance rates for almost all lines of insurance are determined by State, based on a review of that State's data for that particular line of insurance, and for the particular coverages under consideration. It is a very refined and detailed analysis.

Product liability rates are based on countrywide experience. That is an exception.

It is also important to recognize that the prices or premiums charged in the marketplace can and often do vary significantly from, for example, the advisory rates as developed and distributed by a rate service organization such as ISO. ISO's advisory rates, which are developed by ISO staff and not by insurer committees, represent an actuarially valid average rate level for an average risk in each particular class.

Insurers frequently depart from ISO advisory rate levels; and, by the way, most often down, not up. And they have independent programs, particularly for package policies, which are independently priced.

Reasons for use of other than an ISO advisory rate are many. Individual insurers do not all write an average book of business, but must evaluate their own markets by class and type of risk to determine the appropriate price they should charge. Insurers have different means of marketing their products, as well, so the expense elements will vary. And, perhaps most importantly, individual insurers must assess their own profit goals, their own market share projections, and their own investment income capabilities, to evaluate what their individual market prices should be to achieve those goals.

In addition to these considerations, the use of experience and schedule rating programs provides a great deal of flexibility to underwriters in their assessments of the underlying exposure and the appropriate price to charge each individual risk. In some instances, the actual and current losses for a particular risk may be used in pricing that risk; but it will only be used to the extent credible in individual risk rating programs.

But it is also important to emphasize that the absence of a claims history does not indicate and is no assurance that claims will not occur in the future. This is perhaps one of the least understood aspects of insurance pricing.

Ultimately, insurance rates and prices are a function of loss costs. Premiums must be determined in advance before the costs of providing that coverage are actually known. But insurers use past data as an indicator of future loss levels; but they make adjustments to that past data to reflect known or anticipated changes likely to affect insurance claims experience.

This kind of an analysis is not and cannot be done on an individual risk basis, however. Neither is it done too broadly. It is done on a line-by-line, State-by-State basis. And within each line of insurance—for example, owners, landlords, and tenants, which is a subset or a subline of general liability insurance—OL&T is looked at separately for each coverage, bodily injury and property damage liability.

A further differentiation is made by class groups, and still further by individual classifications. For example, day care facilities: By using classifications, insurers are able to group insureds with similar risk characteristics, and so use the experience of those similar homogeneous insureds to determine the appropriate class average rates.

Even when reviewing the experience from each class and class group, past claims history may become virtually useless in predicting future loss experience, if there has been a material change in legal or social environment. For example, the historical claims history for a municipality or a Government entity, which had in the past enjoyed a significant degree of sovereign immunity, would be totally irrelevant in evaluating the proper price for that municipality if sovereign immunity is removed. And, as indicated earlier, competitive strategies, marketing considerations, growth and market share priorities, as well as other factors, can influence an individual insurer's perspective or judgment regarding the appropriate price to quote for a particular commercial risk.

Finally, just a few short words about the effect of tort reform and expectations about cost and availability of insurance in the future. I do not believe that anyone can estimate quantitatively what effect any of the measures frequently discussed will have on overall loss costs in the future, much less what the effect is likely to be on premiums. There are simply too many unknown and entirely unpredictable, if not conflicting, pressures which will continue to influence loss costs.

But even if a totally omniscient actuary could be found to do the impossible task just described, that task would have to be duplicated many times over in each and every State to reflect economic, social, legal and political considerations in that State by line of insurance, by coverage, as well as reflecting the then current adequacy or inadequacy in rates by line, by State, by coverage.

Having said that, on a more positive note I do believe that if effective—emphasize "effective"—tort reform measures are enacted, and if they are not reversed or eliminated via judicial challenge, then insurance prices will inevitably be favorably affected by such measures.

In other words, what I am saying very simply is, prices will be lower than they would otherwise be in the absence of such reforms, and the effect on availability of coverage is also likely to be favorable, as well.

Measures which improve an underwriters confidence in the ability to assess the future environment will encourage greater insurance participation in the marketplace.

That concludes my remarks, Mr. Chairman. I would be pleased to try and answer any questions you might have.

[The statement of Ms. Walters follows:]

STATEMENT OF
MAVIS A. WALTERS
SENIOR VICE PRESIDENT
INSURANCE SERVICES OFFICE, INC.

I am Mavis A. Walters, Senior Vice President of Insurance Services Office, Inc. I am a Fellow of the Casualty Actuarial Society (CAS) and a member of the American Academy of Actuaries, and currently serve as an elected member of the Board of Directors of the CAS.

Insurance Services Office, Inc. (ISO) is a non-profit corporation that makes available rating, statistical, actuarial, policy form and related services to any U.S. property/casualty insurer. ISO provides advisory research services to more than 1300 property/casualty insurance companies in the U.S. ISO is not a trade association and therefore does not engage in lobbying on behalf of insurers.

ISO has no mandatory membership requirements, nor do we have adherence requirements with respect to advisory rates, loss costs, policy forms or programs. In fact, we actively encourage independent action by participating insurance companies. ISO is committed to providing the information tools that will help its participating insurers serve the insurance-buying public.

We serve participating insurers by gathering, storing and disseminating statistical information to regulators, as required by law, and to insurers for their own use. We also develop and assist in implementing programs that help define and cover risk. In most states, we promulgate advisory rates or advisory prospective loss costs for sixteen lines of insurance including personal lines (automobile and homeowners) and commercial lines of insurance such as General Liability.

During the past year, the availability of property/casualty insurance for many businesses and commercial enterprises has become a major public issue. Insurers have had to raise prices dramatically. In some instances they have made the determination that certain classes of business may simply be uninsurable. To put this into perspective, it is necessary to understand and appreciate the financial condition of the property/casualty insurance industry.

While much has been written about the financial distress experienced by this industry it is well worthwhile to review some of the most important economic considerations. It is beyond dispute that 1984 was the worst year to date for property/casualty insurers with net income after taxes falling to $1.3 billion producing a return on net worth of only 1.7%. That was 12 points lower than the Fortune 500 companies' median return of 13.6% in 1984. The estimated results for 1985 do not show any significant improvement. Net after-tax income grew to $3.5 billion for a return on net worth of only 3.8%, still about 10 points below the Fortune 500. (All the figures for the property/casualty business have been adjusted from Statutory to Generally Accepted Accounting Principles).

The deterioration in results has not fallen evenly among insurers. Companies that insure the nation's businesses and commercial enterprises have been the hardest hit. By 1984, insurers writing predominantly commercial lines experienced a negative 3% return on net worth. And reinsurers, who have become a very important segment of the industry, had disastrous results in the last couple of years. In 1984 their return on net worth plummeted to -10% or nearly 12 points below the industry average. While 1985 results for reinsurers are not yet available an unacceptably low return on net worth is a certainty once again.

To understand why profitability has been so low one must examine the most important component of net after-tax income - and that is Operating Income. This figure is the sum of underwriting income and investment income. It represents the profit or loss from insurance operations. Underwriting income (the difference between premiums earned and the sum of claims, expenses, and policyholder dividends) has actually been an underwriting loss beginning in 1979. And underwriting losses have grown each subsequent year reaching $21.5 billion in 1984 and a staggering $25 billion in 1985. These underwriting losses didn't result from the widespread insuring of "bad risks" as some have alleged, but simply from insurance being provided at prices that were, in hindsight, too low.

Prior to 1984, the industry's investment income (the interest and dividends received on investments) was sufficient to offset underwriting losses in every year, except for 1975, thereby producing a positive operating profit. In 1975, investment income fell short of underwriting losses by a modest $300 million thus producing the first operating loss. In 1984, a new record was set, with underwriting losses exceeding investment income by $3.8 billion. In 1985, we recorded another record operating loss, this time by over $5 billion. This point is worthy of emphasis. In 1984 and 1985 property-casualty insurers lost money on the insurance business. The only reason there was any positive net after-tax income in the latest 2 years was because of unusually large amounts of realized capital gains and tax credits.

The property-casualty insurance industry benefited from nearly $5 billion of realized capital gains and tax credits in 1984 and over $7 billion in 1985. For the twenty year period prior to 1984, the average of total capital gains and federal income taxes was a net of only $500 million a year. Clearly, given their historically small contribution to total profit, these items cannot and should not be relied upon to provide a continuing and consistent bailout for operating losses. If the property-casualty industry is to survive and grow, over the long term a reasonable and healthy level of profits must come from insurance operations.

But, as the 1984 and 1985 figures demonstrate, positive operating income - the difference between underwriting loss (after policyholder dividends) and investment income - has been hard to achieve. Although investment income has grown steadily over the last decade to $18 billion in 1984, its average annual increase since 1980 has been less than $2 billion, while underwriting losses increased at an average annual rate of over $4 billion. The 1985 investment income growth of $1.8 billion was overshadowed by the $3.2 billion increase in underwriting losses thereby producing an even larger pre-tax operating loss last year. The only way to achieve positive operating income will be for premium increases to overcome the continuing growth in insurance loss costs.

Unfortunately, many people do not understand the critical need for current premium increases some of which are quite large particularly for commercial liability insurance coverages. The explanation is two-fold. Price levels in the past have been far too low. From 1979 through 1984 insurers could and did provide insurance to commercial customers at very low premiums in recognition of the anticipated investment income that could be earned by investing those premium dollars. While customers did benefit from low prices during those years, by the end of 1984 it became apparent that insurers had reduced prices far below the level needed to cover actual loss costs.

But there is another element, besides past inadequate prices which is driving up insurance premiums today and that is the extraordinary growth in losses. In the past 5 years, growth in property-casualty losses has far exceeded the country's economic growth as measured by GNP.

During 1979-1984, GNP grew 50% while written premium increased only 34%, or 2.4 points per year slower than the average annual GNP growth rate. On the other hand, paid losses overall grew 76%, or 3.4 points per year faster than GNP. Moreover, the increase in losses was not uniform across all lines of insurance. Commercial lines paid losses grew 92% and commercial liability paid losses increased 130% during the period -- well over double the GNP growth rate.

For the most troublesome lines, general liability and medical professional liability, paid losses have grown 167% over the 5 year period -- more than triple GNP growth. While availability and affordability problems are certainly due in part to past price reductions a major contributor to the problem has been this significant increase in losses.

It should be understood that large premium increases occurring now, particularly for the commercial liability lines, will not recoup past losses or make up for recent substandard profits. Insurers can't make up or get back money they have lost in the past two years. It is simply gone. Premium increases today are needed simply to bring today's insurance prices up to the level of losses expected to be paid under today's insurance policies. Insurers want to be certain that the premium they charge for current insurance policies won't result in future losses as has happened in the past 2 years. It should also be understood that today's premium increases are not making up for investment losses as some mistakenly believe. Investment income continues to grow but not sufficiently to overcome the huge losses resulting from prior inadequate prices. Insurers must increase prices to the level where they will be sufficient to cover the losses which will be paid under today's policies.

Some critics have charged that insurance industry financial figures are misleading and distorted since their incurred losses contain estimates of future loss payments which are often overstated. The industry manufactured the last medical malpractice "crisis" by overreserving and has done the same thing this time, so the critics allege.

Not only does this charge have no basis in fact but it also contradicts the consensus opinion of recognized financial experts, including the most widely known and respected Wall Street analysts, who continue to believe that the property-casualty industry is underreserved. Furthermore, time has shown that, at the time of the last crisis in 1976, industry loss reserves were seriously understated.

At the time of the last crisis -- 1976 -- the reserves set aside at year-end 1976, for all claims incurred to that date were $47.1 billion. As of year-end 1984, $48.6 billion had been paid out on those initial pre-1977 claim reserves. And an additional $8.0 billion was still held in reserve for the same group of claims -- for a total payment of $56.6 billion rather than the $47.1 billion originally expected. The nearly $10 billion difference represents an initial reserve deficiency of 20%.

A fuller discussion of these points and others, as well as explanatory charts, graphs and exhibits are included in the ISO document; Insurer Profitability - The Facts.

While the dismal financial results of the property-casualty industry over the past two years are an historical fact, some have suggested that this distress was caused by insurers' own aggressive price competition over the past six or seven years. Others assert that today's problems are soley a function of the excesses or distortions in our civil justice system. I believe the truth lies somewhere in between.

While the industry's financial results are partly the result of aggressive competition, the industry has also been a victim of fundamental changes in the civil justice system during the past several years. As a result, the availability and cost of insurance for current liability is significantly influenced by insurers' concern about the magnitude of potential liability, both past and future; by the seeming inability to use contract language to prudently limit insurers' exposure; and by a system that continues to create new theories of liability and to expand older theories, at the same time that traditional legal defenses are being eroded.

However, while current insurance availability and affordability problems are in part result of our present legal system in the U.S., insurers have not been sitting by doing nothing. Rather we have over the past several years developed a new modernized, simplified commercial general liability policy form to respond to current marketplace needs. This policy form represents a reasoned attempt to deal with the realities of the legal and social environment now and in the future.

The new CGL program offers a choice between 2 attractive alternative versions of a Commercial General Liability policy form. One - the "occurrence" version will provide coverage for bodily injury, and property damage that occurs during the policy period. The other - the "claim made" version will provide coverage if the claim for damages for bodily injury or property damage is first made during the policy period. The only differences between the two versions are in the provision related to what triggers coverage.

We expect that the availability of a claims-made policy will increase availability of insurance in those instances where occurrence coverage simply cannot be underwritten or priced accurately, and will allow insurers to price their products with greater assurance. The benefits and certainties of the new policy transcend the business cycle. For example, rates under the claims made version should have a greater stability over time then rates for the old occurence form.

We do not suggest that the CGL program can or will solve all of the insurance availability or affordability problems of today's marketplace but we are confident that it will be seen as a positive step taken by the industry in these difficult times.

Finally, a few comments need to be made about the data used in ratemaking. Some individuals mistakenly assert that insurance rates are based upon countrywide loss experience and therefore any actions taken to reduce or limit losses in any one state will not produce any benefits to the citizens of that state. The fact is that insurance rates or rate levels for almost all lines of insurance including passenger auto, homeowners, commercial auto or the general liability sublines are determined on a state-by-state basis by reviewing the loss experience in that state for each of the lines and coverages. In addition, there are frequently territorial distinctions made within a state so that different geographical areas such as major cities and towns and rural areas will have different applicable rates based upon their relative loss experience compared with the statewide average. Product liability rates, however, are made on the basis of countrywide experience because of the necessity for a countrywide data base for statistical credibility and because of the obvious ability to transport and use products all over the country.

Classification relativities, on the other hand, i.e., the relationship between and among different rate classes, are determined on the bases of countrywide data. This means, for example, that while the rate relationship between grocery stores and hardware stores would be the same in both Arkansas as in New Jersey, the rates for both types of stores in Arkansas are probably well below the rates for those stores in New Jersey.

It should also be recognized that the prices or premiums charged in the marketplace can, and often do, vary significantly from the rates as developed and distributed by an advisory rate organization such as ISO, or even rates filed by an independent insurer. Insurers frequently depart from ISO rate levels, (most often down, not up), and have independent programs, particularly for package policies, which are independently priced. In addition, the use of experience and schedule rating programs provides a great deal of flexibility to the underwriter in his assessment of the underlying exposure and appropriate prices to charge each individual risk. In some instances the actual incurred losses for a particular risk may be used, to the extent credible, in the individual risk rating programs. However, the absence of a claims history does not indicate that claims will not occur in the future. This is one of the reasons that insurance is purchased, since no one can predict with certainty if and when claims will be incurred for any individual risk. Additionally, past claims history may become virtually useless in predicting future loss experience if there has been a material change in the legal or social environment. For example, the historical claims experience for a municipality which had enjoyed a significant degree of sovereign immunity is not relevant if that sovereign immunity is removed.

Finally, competitive strategies, marketing considerations, growth and market share priorities and other factors can influence an individual insurer's perspective or judgment regarding the appropriate price to quote for a commercial risk.

Chairman **Pickle**. Thank you, Ms. Walters.

In the interest of time, I am going to try to summarize the two positions and ask you to make a response; and then we might have a joint discussion with you and the others from the GAO.

Was it appropriate for insurance premium rates to increase as they did in 1984 and 1985? The General Accounting Office said no. They said they looked at two insurance lines—medical malpractice and commercial general liability. To break even, they said that insurers should only have increased premiums by 20 to 30 percent, respectively.

How would you respond to that?

Ms. **Walters**. With all due respect, I would respond that the General Accounting Office is wrong; 1984 and 1985, as our results showed, were the 2 worst years in the history of the property/casualty insurance business. To suggest that merely a 20-percent increase in premiums for either general liability or medical malpractice would have turned those dismal results into a breakeven point is virtually impossible.

Let me cite that the combined loss ratio for medical malpractice in 1984 was 162; in 1985, it was 166. That means it took $166 out of every $100 of premium earned to cover incurred losses. That doesn't involve expenses or anything else.

For general liability, the comparable figures were 151 in 1984 and 150 in 1985. So, it is virtually impossible to say that if insurers had charged 20 percent more, those numbers would have turned into either a breakeven or a positive, is impossible.

It was clear to me, sitting in the back of the room listening to the discussion, where a lot of the confusion lies. The confusion lies in trying to evaluate rate level, or rate level, adequacies or inadequacies, on the basis of financial data. The numbers that we have cited mostly here, and in talking about insurer profitability, the only source of data to use is, of course, insurer financial statements, which is what we all get.

The source of that data is from A.M. Best Co. GAO and we look at it. The ultimate results are insurance financial statements filed with each and every regulatory authority. Those financial statements are intended to evaluate overall solvency and solidity and provide a picture of the total financial results of companies.

Rate level needs, however, cannot be evaluated on an overall countrywide summarized basis. They have to be looked at by line, by State, by coverage. And the source of that data are data filed under statistical plans.

Chairman **Pickle**. I have some observations to make on those. I want to ask you to try to respond briefly, because we only have 30 minutes and we have several Members who want to ask questions. If you could kind of give me as quick a response as you can.

With the insurance companies in a bad financial state, and the GAO says it is cyclical, and what you have said about 1984 being another bad period of insurance profitability and that the insurance business interests are now turning around and they, therefore, don't need these huge increases, what is your response?

Ms. **Walters**. My response is, of course the insurance business is cyclical; 1984 and 1985 don't represent a typical cycle, but we won't debate that here.

Yes, financial results are turning around. They are starting to turn around. They are still at dismally totally unacceptable levels. A 3.8-percent total return on net worth for one of the riskiest businesses in the total economy cannot be accepted by anyone.

The reason it is turning around, though, is that insurers are now starting to move prices closer to the point where they will be sufficient to cover claims in the future. They are still not there. They have got to continue to move up so that prices will be sufficient to cover claims that will be incurred under those insurance policies.

They are also applying stricter underwriting standards and guidelines. There was some talk in the GAO discussion about what is discretionary on behalf of insurers. Certainly, it is discretionary on their behalf as to whether or not they have confidence in their ability to price the product accurately.

Chairman PICKLE. You are assuming it is not profitable. The difference is you look at the net worth of the companies.

Ms. WALTERS. I don't think GAO disagrees. I don't think they were saying they believed profitability today is at an acceptable level. I think we are in agreement on that point.

Chairman PICKLE. Another question is, where does the problem with the insurance companies lie? Medical malpractice and commercial general liability—where do they actually fit in the big picture? GAO said it is really a small portion; that medical malpractice is only 2.6 percent of the premiums paid; and general liability is 11 percent. Therefore, the overall health of the industry is not in jeopardy.

How would you respond to that?

Ms. WALTERS. I would respond in two ways. Referring back to the very numbers you cited, medical malpractice was about 2 percent of industry premiums.

Is that right?

Chairman PICKLE. Yes, 2.6.

Ms. WALTERS. Yet, it represents 6.4 percent of the total industry losses.

General liability premiums, which represent roughly 6 or 7 percent of industry premiums, represents 21 percent of industry losses.

Clearly, they are problem areas. They are the worst problem areas. That is why we tend to focus on them.

But, 3.8-percent return on net worth, $25 billion of operating losses, didn't come solely from those lines of insurance. We talk about them most because they have the worst problems.

There are also problems in other commercial lines—commercial auto liability, commercial multiperil, worker's compensation; and unless premiums are increased at some significant levels this year for the personal lines, we will see further deterioration in those lines, as well.

Chairman PICKLE. Let me be more specific here because we seem to be going in circles.

Some surgeons' policies have increased from $20,000 to $30,000 a year up to $80,000 or $100,000 or in excess. Is that acceptable, in your judgment?

Ms. WALTERS. Without analyzing the data that supports that, I can't make a determination.

Chairman PICKLE. We hear these examples over and over again.

Ms. **Walters**. Correct.

Chairman **Pickle**. That is just one field. There are many, many others where the premiums have gone up anywhere from 10 to 500 and 600 percent in one short time, and that is hard to understand.

Ms. **Walters**. That is right.

Chairman **Pickle**. Your study group has recommended that they change the tort system, and you say in response to that there is a question—you have studied the historical increases, losses, and profits of the industry—whether to make changes in the tort system. You said it is probably in between; that the truth lies somewhere in between.

Now, my question to you is, if tort reform as proposed won't solve this crisis, what else needs to be done to guarantee more affordable insurance for the individual? You, yourself, said the answer doesn't lie there. If it doesn't, where does it lie?

Ms. **Walters**. I think my statement was directed to how did we get where we were at. I said I think it is only fair to say that there are two aspects to getting to the point where we are at now. One is aggressive price competition, which drove prices lower; and the other, at the same time that that was happening, loss levels were increasing at a rate that never could have been predicted, as we showed on our charts here, far beyond any standard measure of economic growth.

People are saying increasing losses are not the problem. They simply ignore reality. I think both of those things have been going on at the same time.

Frankly, my position may not be the position of a lot of the insurance trade associations. My position is that the insurance industry eventually will recover its profitability. It will do so the way it has done before, by increasing prices and by being more astute and more careful in its underwriting.

I do not believe that in the long run the insurance industry wins or loses under any tort system. The insurance industry is primarily a financing mechanism for paying claims, and it can function no matter what the claims environment is. But it will do so at an increasing rate.

Chairman **Pickle**. What you are saying is that you don't think the tort system reform itself is going to make that big a difference?

Ms. **Walters**. It depends on to whom, Mr. Chairman. I think ultimately to insurers it may not, because of two reasons. They will increase prices so that those prices will be sufficient to cover all of the claims and all of the losses that will be paid. They will also recover—insurers will recover, because they will continue to do what they are doing now.

They will take a look at certain classes of business and try to make the determination as to whether they believe they can, at any price, write that business with a reasonable chance of generating an operating profit. Today, they are saying for many classes of business, no.

I have got stockholders; I have got other policyholders. I have no confidence in my ability to insure an arm of a government; for example, a municipality; I have no confidence in my ability to price that to cover unforeseen events that that insurance will be called upon to pay.

Chairman Pickle. Thank you.

Mr. McGrath.

Mr. McGrath. Thank you, Mr. Chairman.

Ms. Walters, what you are saying is that the insurance industry is relatively profitable as compared to other corporations in the Fortune 500 over the last, let's say, 5 years. And the question that comes to my mind is whether or not we should be concerned about the relative profitability of companies, or, rather, should we be concerned about the availability of the product, if the relative profitability is not there. And I just want you to react to that.

Ms. Walters. Well, I would call it relative unprofitability of the industry, compared to all other industries in the American economy. And second, I would say we all need to be concerned about that, because to the extent that insurers go under—and we had a record number of insurance insolvencies in 1984 and 1985; we have seen a record number of companies go on the watchlist for the NAIC, and we have seen a record number of companies have their ratings by the A.M. Best Co. deteriorate in the most recent few years.

Availability of insurance is certainly a function of the suppliers, the number of suppliers out there. To the extent that insurance companies are financially weakened and damaged, as many have been over the last several years, that is going to affect the ability of the industry to provide the coverage for the American economy.

Mr. McGrath. You made the point that if we were to examine how tort reform would affect prices, we would have to look at every product line, in every State. I want to get into the rate-making area.

A few years ago the New York State Insurance Commission left the prior approval of rates to a fair market approach of rate-setting. Of course no one really knew how this was going to affect the rate structure.

I am wondering what is the public policy of the Federal Government, when we find that prices, according to your service, are too low, and yet the policy of companies is to even further reduce the price of policies in the profitable times?

Ms. Walters. Let me answer that in two ways, Mr. McGrath, if I could.

First of all, I am going to say virtually all—because I can't think of any to the exception—economic studies that have been done on the property/casualty industry recently—and most recently the Federal Trade Commission did a study which isn't talked about very much by the critics because it comes to the "wrong conclusions"—but the FTC did a study last year to ascertain whether there is a real difference between prior approval type States and competitive rating States, and found that, yes, there is a difference, and the difference is in competitive rating States the consumers are better off than the prior approval States.

So, I do not believe in a competitive environment with literally hundreds, if not thousands, of competing entities, that prior approval serves the public interest in the long run.

What we are talking about now is something that is a very unusual situation, and frankly one thing that might have been done would be to reimpose cartel-type pricing, to tell sellers and buyers no, you can't have the benefit of those very low prices in times of profitability. If there are willing buyers who want to provide a product at low prices, is any regulator, or any politician, for that matter, willing to say no, I am not going to let those low prices go into effect?

So, if we go back to cartel pricing and hold prices inordinately high, then we won't see great swings. But, yet, consumers won't get the benefit of the low prices during those times.

Mr. **McGrath**. But in the situation that we find ourselves now, consumers are finding themselves without insurance and prices 300 percent higher.

I am just wondering whether or not on a policy public basis there is any role for any level of government in insuring the profitability of companies so consumers will be able to afford and obtain insurance?

My final is if we can't define what the effects of tort reform or the components of tort reform are going to be on insurance rates or availability, then how do we know we are doing the right thing, other than it is logical?

Ms. **Walters**. I suggest I am the wrong person. I am not a lawyer. I am the wrong person to deal with tort reform.

Mr. **McGrath**. You know the numbers.

Ms. **Walters**. Sir?

Mr. **McGrath**. You know the numbers, the components.

Ms. **Walters**. You mean the effect?

Mr. **McGrath**. Yes.

Ms. **Walters**. Yes; as I said in my statement, since rates are made on a line-by-line, State-by-State, coverage-by-coverage basis, the only way to evaluate the effect of anything is on that same basis, because auto rates in South Dakota are not affected the same way homeowners' rates in New Jersey are, or product liability rates in South Carolina, or physicians', surgeons' and dentists' rates in Pennsylvania are. They are all different, and a consistent, valid evaluation has got to be made in each State on the basis of current rate levels, on the basis of current social and legal environments and everything else that goes into determination of those things that affect what insurance pays for them.

That is the honest answer. Now, it is not an easy one, but it is the honest one.

Mr. **McGrath**. Thank you, Mr. Chairman.

Chairman **Pickle**. Mr. Anthony.

Mr. **Anthony**. Thank you, Mr. Chairman.

Welcome, Ms. Walters.

If that is the case, why would day care centers in the State of Arkansas have difficulty even finding a company that would write insurance? Why would day care centers pull out of Colorado when they paid out $50,000 in losses and collected $500,000 in premiums?

Ms. **Walters**. You are citing—I am glad you cited that one example, because it will help me to explain the complexity, even with something as simple as day care centers.

Day care insurance is provided, and has always been provided, in lots of different ways, either under commercial insurance policies, a class of business under "Owners, Landlords and Tenants," or in many ways in many States it was provided to inhome providers under their homeowners' insurance rates.

The fact is that until the end of 1984, a major player in the day care insurance marketplace, commercial insurance marketplace, was an insurer from California who is now bankrupt. They made it their business to become the major underwriter of that class of business. They, in effect, wrote it at very low rates and provided the major market for it. They went bankrupt.

When they went bankrupt—and, of course, all the insurance policies that had been written in that bankrupt company were gone, were now on the market, at a time when the operating losses for the entire property/casualty industry were turning negative, at a time when insurers' capacity was reduced, and at a time when incredible publicity was being given to cases of abuse of children—not, by the way, just in one or two States or counties.

I reviewed a clipping file before testifying on that very subject, and I was astounded at the number of cases all over the country, some of them in very small communities where you would not have expected it.

Mr. ANTHONY. May I ask a question here?

Have you conducted a further study to find out how truthful those clippings were? In other words, how many dollars in settlements actually went out as a result of this?

Ms. WALTERS. We can't tell what went out, strictly because of abuse cases. But we do know that the relationship of losses to premiums is extremely high in 1984, and went higher in 1985, on a countrywide basis. So, the claims are there and the claims are being made.

Mr. ANTHONY. Under day care?

Ms. WALTERS. Yes.

Mr. ANTHONY. Can you provide that information for the record?

Ms. WALTERS. I sure can. In fact, I have it with me. I just can't pull it out.

[See response at p. 1042.]

Mr. ANTHONY. Would you also provide information with relation to abuse cases?

Ms. WALTERS. No, we don't have that detail. In fact, a lot of those——

Mr. ANTHONY. Is it available?

Ms. WALTERS. No, I don't believe it is available yet, because a lot of those, I believe, are still working their way through the legal system; and until all legal remedies are resolved, they will not work their way through the insurance industry.

Mr. ANTHONY. Is it possible for this subcommittee to get two pieces of information from the industry—one, the total amount of claims paid out without going to court; and the total lawsuits that are presently pending in the court system?

Ms. WALTERS. I have no idea—no, I don't believe that data is available, and I don't know how to get it.

Mr. ANTHONY. That data is not available.

How, then, are we to make a decision as to who is at fault and whether or not a day care center in Arkansas can get a policy?

Ms. **Walters**. I think we have to remember the insurance mechanism is a funding mechanism. It is not a mechanism for redistributing societal values, although sometimes it turns out to be.

What we evaluate as actuaries in determining prices is how much has to be paid in claims, what are the claims as it relates to the premium incurred, and if the claims are higher than the premium incurred then you have to raise the premiums so it will be sufficient to cover future claims.

It doesn't matter whether you are settling those claims for abuse, whether you are settling them because the house burned down and the kids got burned, or whether you are settling them because Johnny punched Suzie.

What insurance companies need to do is have the money from premiums to pay the claims.

Mr. **Anthony**. So, the same analogy would hold true for homeowners?

Ms. **Walters**. In terms of premiums and losses?

Mr. **Anthony**. Yes.

Ms. **Walters**. Exactly. That is exactly the way insurance rates are made.

Mr. **Anthony**. Automobiles?

Ms. **Walters**. Exactly.

Mr. **Anthony**. General liability, including municipal?

Ms. **Walters**. Yes.

Mr. **Anthony**. Commercial business?

Ms. **Walters**. That is right.

Mr. **Anthony**. Product liability?

You just mentioned day care, and I assume that you would also include nonprofits such as YWCA's, nonprofits that perform services such as adoption services, et cetera?

Ms. **Walters**. Exactly. We analyze rate level increases by looking at current premium levels, compared to the loss levels expected to prevail when the new premiums are going to be charged: Will those premiums cover those losses?

Mr. **Anthony**. So, you are saying that the data that you have in your file shows that nationwide for nonprofits such as YWCA's, that their loss experience has greatly exceeded the premiums collected?

Ms. **Walters**. I believe that is true. I haven't looked at that particularly.

Mr. **Anthony**. So, when we have witnesses that have come in here and stated that they have paid 50 years of premiums and have never filed a claim, and that they do not even know of an agency in their association that has filed a claim, yet they were given 300 and 400 percent increases, your data will back up the insurance company?

If your answer is yes, would you provide the data for the record?

Ms. **Walters**. What I would try to explain in my direct statement was that there are many people who have never had a claim, and yet their premiums have to go up.

Frankly, Mr. Anthony, the same answer goes to those people as would go to someone—and we all know it; in fact, we all may be examples of it—of having had auto insurance all of our lives, drive our car every year and never have a claim, and yet our premium goes up invariably.

Mr. ANTHONY. I understand the concept.

Ms. WALTERS. It is exactly the same.

Mr. ANTHONY. I am not worried about that. I understand.

Mr. Chairman, my time has expired; but if we are not allowed a second round of questions, then I would ask permission to address some questions in writing to the witness.

Chairman PICKLE. Let me say, we said we were going to conclude this hearing at 11. We are going to extend that time a bit, and we have so notified the IRS Commissioner and his staff so that they could gauge their time better.

So, we will come back. I want to get the group together. We will come back to you.

The Chair now recognizes Mr. Guarini.

The Chair also wants to observe we are pleased and honored to have Chairman Sam Gibbons with us, who may want to ask some questions, and we will recognize him after Mr. Guarini.

Mr. Guarini.

Mr. GUARINI. Thank you.

Ms. Walters, so I understand, your capacity here is defending the insurance companies; that is, the capacity of ISO?

Ms. WALTERS. I wouldn't exactly put it that way.

Mr. GUARINI. Let's be very clear. I want to know where you are coming from.

Are you objective in your presentation?

Ms. WALTERS. I believe so.

Mr. GUARINI. Or are you a defender of the insurance industry? It is very simple.

Ms. WALTERS. I believe that the Insurance Service Office has the reputation deservedly for being an objective source of data, statistics, financial information about the property/casualty industry. But, of course, we are not an independent organization. We are an organization of the property/casualty insurance industry.

Mr. GUARINI. And you are funded by the insurance industry?

Ms. WALTERS. Of course.

Mr. GUARINI. So, therefore, you are their spokesman.

Your income comes from that; is that correct? Yes or no?

Ms. WALTERS. Income figures, generally you think of that in terms of individual company information; but, yes, I will accept a yes.

Mr. GUARINI. And all these data and statistics that you acquire are used by insurance companies in their pricing; is that correct?

Ms. WALTERS. Not necessarily, no.

Mr. GUARINI. Aren't you an accumulator of data and information?

Ms. WALTERS. Yes. We are one of many accumulators of data and information. One of the services we do provide is advisory ratemaking information.

Mr. GUARINI. You do advise them on pricing the product?

Ms. WALTERS. Yes, we do.

Mr. GUARINI. And, therefore, you advise them on how their policy is constructed, also, or just on the pricing?

Ms. WALTERS. We do also develop advisory policy forms, that is correct. But I should note quickly on both rates and forms, although we are a centralized organization that provides that service, by no means do all insurers use that information or adhere to those rates or use those policy forms.

Mr. GUARINI. But they ask you for your advice on pricing, if two companies have the same policy and they ask you for the data?

Ms. WALTERS. No, that is not the way it works. The way it works is that we, as a statistical agent, receive information, data, statistics that are filed with us in accordance with our statistical plan. We use that data for all companies reporting statistics to ISO, to develop for those lines of insurance under our jurisdiction advisory rates or advisory loss costs.

Mr. GUARINI. So, therefore, the same product from two different companies would be an advisory price that you would give them, so it would be necessarily the same price that you would give them for the identical product.

Ms. WALTERS. Yes. If I am understanding your question correctly, we develop an advisory rate for a line, for a State, by coverage using all of the data reported to us. We are not like a consulting firm for individual companies. We don't take their own data base but use the combined data base.

Mr. GUARINI. Let me get on to your statistics. You said the net worth is 3.8 percent.

Ms. WALTERS. Return on net worth in 1985.

Mr. GUARINI. And 1.7 percent in 1984; is that correct?

Ms. WALTERS. That is correct.

Mr. GUARINI. All right. Now the 10 top companies that account for half the premiums and assets roughly, what is their average net worth? How much money have they made? Are the statistics different?

Ms. WALTERS. I don't have those numbers separately by company. We did an analysis based on figures through 1984 separately for those companies who were predominantly commercial lines writers and those predominantly personal lines writers. The experience has not been as dramatically bad as in commercial lines, and we found in 1984 companies that were predominantly commercial lines writers had, in fact, a negative return on net worth and that 330 insurer groups, representing 40 percent of the premium volume, had negative returns on net worth.

Mr. GUARINI. The predominant investments are tax-free bonds in most of these companies, is that correct?

Ms. WALTERS. This varies tremendously from insurer to insurer and book of business. But the last figures I saw indicated that about 40 percent of insurers' investment income came from tax-free municipals.

Mr. GUARINI. The bond market has gone up considerably. Does this profit reflect this year as a result of the rise in prices, the bond market?

Ms. WALTERS. It would be——

Chairman PICKLE. Would that change their net worth or the profit that they are getting markedly if there was depreciation of value?

Ms. WALTERS. If they were to realize the capital gains, it would be, yes.

Mr. GUARINI. Does this show in your statistics you presented to us——

Ms. WALTERS. Yes, it certainly does.

Mr. GUARINI [continuing]. What the current value of those bonds are?

Ms. WALTERS. Not as of today, of course, but our figures through 1985, yes. I don't know if you were here for my statement, the only reason there was any net income at all for this industry in 1985 was because they did sell assets and realized unprecedented levels of realized capital gains.

Mr. GUARINI. So, therefore, we would expect this year they would not only get tremendous increases in their premiums on their policies, but also would get a windfall as a result of what has happened in a bond market, is that correct?

Ms. WALTERS. I am not going to try to predict the stock market. As of today——

Mr. GUARINI. There is no question that the stock prices are going up all the time on these companies that you are testifying that are in such deplorable condition and that they are doing better and that—one of the hottest industries on the stock market, is that correct?

Ms. WALTERS. That is correct. Would you like me to explain?

Mr. GUARINI. How do you explain that if there is such a doldrums and terrible loss that they are so sought after in the marketplace?

Ms. WALTERS. It is a very fundamental tenet of investment policy. Investors are drawn by expectations of future profits. Yes, the profitability of the property casualty industry was dismal in 1984 and 1985.

Mr. GUARINI. The expectations are——

Ms. WALTERS. The expectations will improve. We are all aware of that well known tenet of investments, you buy low and sell high. With a 1.7-percent net worth return in 1984, how could they do anything but improve in 1985 and 1986?

Mr. GUARINI. How do we protect the consumer? That is our job. We know you can file your rate in any of these States, but there has to be an answer where we can stop the cyclical swings we have. How do we protect the public and the consumer? This goes into consumer prices. Every manufacturer has to put it in, every doctor has to crank it into the ultimate price of their product.

You have come before us and told us things are dismal in the industry, you must charge these huge swings. How do we stop these swings from happening, and what suggestions do you have to this committee as to how we can go about protecting the consumer?

Ms. WALTERS. The first thing, I guess I haven't made clear up to now, and I should, past losses—by past losses I mean the dismal profitability of insurers are not a factor in today's prices. The prices that insurance companies are charging today are prices that are meant to cover the claims that they are going to have to pay in the future. Those prices aren't making up for past inadequate profits or recouping past losses. Loss levels have continued to go up as these charts have shown. Loss levels are outstripping premium increases.

There is, as Milt Freeman said, no such thing as a free lunch. As long as the U.S. Treasury hasn't granted insurers the right to print money, the way they get the funds to cover all those losses is by charging premiums that will be sufficient.

Mr. **Guarini**. Yes, but you haven't answered my question. You said there are new policies that you are devising in your testimony, and then you said that during the claims that are made during the duration of the policy period, that means that if a person, from what I understand, has a claim against them and that insurance company policy period expired, that member of the public would not be protected for that claim, is that correct?

Ms. **Walters**. That is not necessarily true at all. I am afraid there is a lot of misunderstanding about the policy. There is a 5-year tail, there is a provision guarantee.

Mr. **Guarini**. But you are cutting down the coverage of the individual, and that is why it is cheaper.

Ms. **Walters**. Only postponing it until it is needed so insurers don't have to buy every single year of continuous coverage, overlapping coverage. It is only deferred. You don't have to buy tail coverage until you need it.

Mr. **Guarini**. My time is up. Perhaps there will be other questions I could ask later. Thank you.

Chairman **Pickle**. Mr. Gibbons, the chair would be pleased to recognize you if you have questions.

Mr. **Gibbons**. Yes, sir, I do, and I am going to expose my ignorance of this industry. First of all, why are you exempt from antitrust laws, and what would happen if you came under antitrust laws like every other American business? As I read your statement, your job would be abolished.

Ms. **Walters**. Maybe yes and maybe no. The joint collection of data and statistics has long been viewed as a critical need to provide actuarially valid rates.

Mr. **Gibbons**. So you do it for everybody in the United States, or just about everybody.

Ms. **Walters**. Only those who choose. Any insurer can choose to——

Mr. **Gibbons**. What percent of the companies do you represent?

Ms. **Walters**. It all depends. By line of insurance and by State.

Mr. **Gibbons**. Let's talk about liability insurance, that is what the subject is about.

Ms. **Walters**. In commercial lines, probably 80 to 95 percent of insurers in some way participate.

Mr. **Gibbons**. They supply you data, and you supply cross-references to those data.

Ms. **Walters**. Not necessarily. It may mean they just provide us with the data. Because every insurance company is required by State law to file their statistics with insurance departments. They may do so independently, or they may do so through a statistical agent. And insurance service's office is one of many statistical agents, so they may affiliate by using us as a statistical agent. They may choose to participate by buying some of our services in one State, in several States, for one subline of insurance, for many sublines of insurance, for forms, for rules and forms, for rates, rules and forms, for actuarial services.

Mr. **Gibbons**. Forms are pretty important, because they are the contract between the consumer and the company.

Ms. **Walters**. That is correct.

Mr. **Gibbons**. Anybody that can understand those has to be a hell of a lot smarter lawyer than I ever was.

Ms. **Walters**. We think one of the distinguishing characteristics of this industry, as opposed to the life industry, is because we have standardized forms and normalized forms for writing insurance coverage—it is much easier for consumers to compare contracts than to compare prices.

Mr. **Gibbons**. I never saw a consumer yet who could—most people who have an IQ of about 400 can't—understand an insurance contract. I have been through those things time and time again, so don't give me that line.

But let me ask you a question. I am looking at Best Insurance Management's reports now of April 17, 1986, and it says last year the industry had little problem in raising new funds from capital bargains, insurance stocks have been in such favor with investors that property casualty stocks on Best's insurance stock index appreciated 50 percent during 1984, 50 percent during 1985, and almost another 22 percent in the first quarter of 1986. In the same 15 months, this industry's stock index has grown by 83 percent, while the Standard & Poors 500 gained only 43 percent.

Now, you know, I am 66 years old, I wasn't born yesterday. People don't invest money in something that is going down hill.

Ms. **Walters**. That is exactly the point.

Mr. **Gibbons**. You are a real profitable industry, and they are buying stock in order to reap the profits.

Ms. **Walters**. No, Mr. Chairman, that is where I would disagree with you. We are not a real profitable industry. I don't take any pleasure in talking about the miserable financial results of this industry. The fact is that the profitability is exceedingly low, it is dismal, but it is improving.

Mr. **Gibbons**. People keep pouring money in faster than the rest of the stock market.

Ms. **Walters**. Because it is obvious to any interested observers that the steps have been taken, those things put in place that need to be put in place.

Mr. **Gibbons**. Your big public relations campaign.

Ms. **Walters**. No, sir, I mean raising prices so they will be sufficient to cover losses in the future and returning to sound underwriting. Stock market prices don't guarantee results, although they do reflect consumer expectations, and it is clear—investor expectations rather—investors and insurers are expecting improved profitability. As I said before, it could hardly be otherwise, with a 1.7-percent return on net worth in 1984. The only direction profits for the property and casualty industry can go is up.

Mr. **Gibbons**. What would happen if we put you under the antitrust laws?

Ms. **Walters**. Of course, I am not a lawyer, but I think every lawyer I have talked to about this has come to different conclusions. It is clear every study that has been done on this subject has made it clear there are certain areas which will need to be protected if we want to maintain the very high level of competition which exists today in this industry. It must be protected because otherwise they could not continue to function, like joint statistical analysis, insurer involvement in standardized forms. There are several areas that need to be protected. If you put two lawyers in a room to agree to those, they will come up with different definitions.

Chairman **Pickle**. Thank you. Now the Chair is going to ask Mr. Finch and Dr. Gandhi if you will come back to the witness table, and, Ms. Walters, we would like you to remain there. The Chair is going to extend the time for another 15 minutes, and we will ask each member, if you have questions, to make your questions as brief or as concise as possible.

My question would be to you, Ms. Walters, for any response you might make. It seems to me that the controversy or the disagreement here is over the question of the worth of profitability coming in. You base your profit and loss basically on the basis of net worth, and your net worth figure was 3.8 percent. That is a lot different from the other Fortune 500 companies.

Now, I presume that you use net worth different from other organizations, because it is a low figure, and, therefore, you can show more loss or don't show as much profitability. That is my assumption. Am I wrong or right?

Ms. **Walters**. Let me correct it. It is a little confused. The 3.8 figure is a return on net worth, return on equity figure. It is a standard measure used by economists and analysts and others to make interindustry comparisons. The 3.8 percent is low, it is higher than last year's 1.7 percent, so it is getting better, but it is still a low result.

I am not sure there is a fundamental disagreement with my colleagues from GAO on the current profitability. We may disagree on what the future profitability is likely to be.

Chairman **Pickle**. I assume you use that figure because it is a low figure, and it makes your figures look better.

Ms. **Walters**. It is just a standard figure.

Chairman **Pickle**. I think we also should make the observation, even if that is the proper approach for your companies, that last year you still made a profit of some $7 to $8 billion.

Ms. **Walters**. No, sir, $3.5 billion.

Chairman **Pickle**. The GAO said you had a profitability somewhere in the neighborhood of about $35 or $36 billion over a period of 5 years, or whatever that period was. Now, I think we ought to keep in mind, even if you used the net worth method, you still made a good profit last year.

So let me ask first, Dr. Gandhi, would you want to respond to that? Am I misstating it, or what is your commentary?

Mr. **Gandhi**. No, sir; I think the question of the rate of return on net worth is entirely all right, and, indeed, those rates were very low in 1984 and 1985. But I think, again, we want to remember that that was the low end of the cycle. Now I can cite the same numbers, say, in 1977, it was around 19 percent, much higher than the Fortune 500.

So if you look at an average rate over the last 10 years, 1975 to 1984, the number that you would get for the property casualty industry is around 11 percent, and the similar number for Fortune 500 is around 13 percent. So when you look at a 10-year number, it is not any appreciably lower number than the rest—either the financial companies or the Fortune 500. You cannot simply look at one or two years, you have to look at a cycle.

Chairman PICKLE. Does any member have any question they want to follow through on?

Mr. ANTHONY. Mr. Chairman.

Chairman PICKLE. Mr. Anthony.

Mr. ANTHONY. I would like to ask this of Ms. Walters. Has the ISO a closed claim survey for product liability?

Ms. WALTERS. Yes, sir.

Mr. ANTHONY. When was that done?

Ms. WALTERS. 1976.

Mr. ANTHONY. What did it cover, what areas did it cover, what product lines did it cover?

Ms. WALTERS. It was product liability insurance.

Mr. ANTHONY. Product liability insurance?

Ms. WALTERS. Which is one subset of general liability insurance.

Mr. ANTHONY. How did you go about getting that information?

Ms. WALTERS. There was a survey form designed by a committee, a joint group of claims people, underwriters and ISO staff, that developed a survey form to see whether or not—well, to develop the questions and to find out whether or not those questions could be answered from claim file information, and then there were volunteers asked for among the companies, "Would you agree to participate in this survey and provide the information?"

Mr. ANTHONY. Did you have good participation?

Ms. WALTERS. Yes; we did. I don't remember the number of insurers.

Mr. ANTHONY. Did it include your resettlements involving and not involving attorneys?

Ms. WALTERS. That was one of the questions asked.

Mr. ANTHONY. Have you done that in 1986?

Ms. WALTERS. No, sir; that was the last study done.

Mr. ANTHONY. Do you have plans to do it in 1986?

Ms. WALTERS. Not at this time, no.

Mr. ANTHONY. So it has been—I don't know the exact year, it was done in the seventies, but——

Ms. WALTERS. 1976, I believe.

Mr. ANTHONY. So it is over 10 years old. What bothers me is you have done it, apparently it was useful, you are not planning to do it now, and we have a difference of opinion just in medical malpractice and commercial general liability. Your counterpart witnesses, sitting right there, have already told us that medical malpractice accounts for only 2.6 percent of all premiums paid and general liability accounts for 11 percent. Therefore, the overall health of the industry, which relies on other insurance lines, is not in jeopardy, and to break even in 1985, GAO reports insurers would only have had to increase premiums by 20 percent and 30 percent respectively.

Yet the testimony that has come before us shows it has been a lot higher than that. Could you do it, and would you be willing to do it in order to help the Congress make its decision?

Ms. **Walters**. The issues that you just raised have nothing to do with the closed claim study. The questions that you just posed to me——

Mr. **Anthony**. Asking for tort reform has everything to do with just what I asked you. The data I have just asked you to collect would set out once and for all whether or not there is a litigation explosion, whether or not jury verdicts are going out of the sky. I think what I just asked you is exactly what this committee and this Congress needs in order to ascertain the correct answers to this problem. Do you disagree with that?

Ms. **Walters**. With all respect, you just asked me about premium increases, justification for premium increases, and how we go about—closed claim studies tell you nothing about—there is no information in there whatsoever which deals with premiums and losses.

Mr. **Anthony**. It tells you about losses.

Ms. **Walters**. A closed claim study——

Mr. **Anthony**. It answers the question, about a $1 million judgment going to someone in Philadelphia because she lost her psychic powers. My information says it is false, Forbes says it is true. They have a bigger circulation than I have. I believe it is false. Your independent study would prove whether it is true or false?

Ms. **Walters**. No, sir; I am afraid it wouldn't.

Mr. **Anthony**. I don't know why the hell it wouldn't. All you have to do is go up there and open the court records to find out what the jury verdict was, fill out a form. It is either yes or no. If it is yes, Forbes is right, I will publicly apologize. If it is no, Forbes should issue a statement saying they misled their readers.

Ms. **Walters**. To get definitive information on a court case, isn't that the kind of information that can be determined from the facts and the files and the pleadings and the decision in the court case? It is not in claim files necessarily.

Chairman **Pickle**. Mr. Guarini.

Mr. **Guarini**. Ms. Walters, that gets to the point of, do you investigate and cross-check all the data information that you collect, or is this data just given by various insurance companies and you act just as a collecting center?

Ms. **Walters**. No; we do have extensive statistical and data quality checks and audits.

Mr. **Guarini**. Do you investigate, do you spot check, investigate to see that your data is correctly given to you?

Ms. **Walters**. Yes; I think, if I understand the sense of your question. We don't go in and redo company claim files, but we do extensive quality control audit statistical checks on the data that is filed with us. In fact, I think we are one of the few organizations that does do that, because we are not only a statistical agency, but we are a rate service organization as well. So it is critical.

Mr. **Guarini**. Do you accept the information given to you from insurance companies or do you verify that information?

Ms. **Walters**. We don't independently verify information by sending out claims examiners, if that is what you mean. No, we don't do that.

Mr. **Guarini**. Have you provided the GAO with all the information that they have requested of you?

Ms. **Walters.** Yes. They have asked us for very little. I have had no contact except for a few-minute conversation with Mr. Gandhi last week.

Mr. **Guarini.** Any other information they need you are willing——

Ms. **Walters.** Let me correct that. There have been examiners or auditors from GAO who routinely come and visit us and have for the last several years, and we have always provided them with everything they have asked for.

Mr. **Guarini.** Mr. Gandhi, have you been satisfied with all the information that has been provided? Have they answered all the questions that you needed?

Mr. **Gandhi.** Yes, sir. But I also want to point out that we have been in touch with the industry over the last several years on a very regular basis, so it is not that we have operated in any sort of vacuum.

Mr. **Guarini.** Ms. Walters, last let me ask you, how can we prevent these wide swings? What mechanism can we put in place?

Ms. **Walters.** That is an excellent question, and I wish there were an easy answer to it, because part of the economics of the property casualty industry, as we all know, are its cyclical nature, and part of the reason for that is because it is an incredibly competitive industry. All of the economists agree. Ease of entry. It is very very easy to get into the insurance business, and when you have a business which is as competitive, and there are periods when the industry becomes profitable, other competitors seek to come in and to cut prices to increase market share, it drive prices down, it drives down profitability. We are at the bottom of the cycle and then we head back up again.

I would suggest, though, there are several things that have happened over the last 7 or 8 years that are quiet atypical, very, very unusual, which led to this trauma, if you will, that we are all facing, both insurers, legislators, regulators and buyers, and several of those factors when we go back to the beginning of the down cycle, we are talking about 21-percent interest rates. In my short lifetime, unprecedented in our economy, I don't know——

Mr. **Guarini.** Isn't this what made them go out and write everything they could and put themselves in a bad position, and isn't that partly why we are in the crisis?

Ms. **Walters.** That is one of the factors. Bad business decisions made by the insurance industry, I don't know if I could characterize them necessarily. It is not that simple. If it were only that simple, it would be easy to get out of it. It is not that simple. Very high interest rates, which insurers recognized, and lower prices because of it, that wasn't necessarily a bad thing for consumers to pay lower prices in recognition of those high interest rates.

In addition, reinsurance, the excess capacity in the worldwide reinsurance market was unprecedented, like what we had never seen before. Reinsurance is the easiest aspect to get into in this business but requires the most sophisticated knowledge. We had new money, noninsurance experience, coming into the reinsurance market thinking they could make a bundle, driving down reinsurance prices so insurers could buy excess coverage for themselves at very cheap prices.

Mr. **Guarini.** I understand that. Now I get to my question. Knowing that these things are a fact of life, knowing what the reinsurance business has been and how they try to grab as much as they can and knowing the greed that exists in human nature, what mechanism can you suggest that we can prevent this wide swing in the future? You didn't answer the question.

Ms. **Walters.** I am trying to. I guess what I am suggesting is the confluence of events that we saw come together in the late 1970's and very early 1980's was highly unusual. I am not certain we are going to see all of those things take place at the same time, and at the same time we saw court decisions rewriting insurance contracts, changing the nature of contract language that we do as an industry have control over. We don't have control over interest rates, but we do have control over insurance contractual language so that we can at least put some kind of perimeters around it, and we have done that.

I think that is going to be helpful in preventing upward spirals in the future.

Mr. **Guarini.** Thank you.

Chairman **Pickle.** Ms. Walters, I want you to submit for the record as soon as you can, the following information.

We would like to have a copy of the advisory rate guidelines—we will give you a copy of these questions—a copy of the commercial statistical plan that is offered by the companies, the rate level history for the past 5 years of certain medical and general liability lines in each State, the actual yearend 1985 results for the property casualty insurance industry, just ended, a copy of the circular, that is the collective financial data sent to member companies, a copy of the special project on experience data by lines of insurance and an example of an advisory rate package submitted to a member company. And we may have other questions we will want to submit to you for your response. We would like you to give that as quickly as possible.

[The information follows:]

INSURANCE SERVICES OFFICE, INC.
900 17TH STREET N.W. SUITE 1010 WASHINGTON D.C. 20006 (202) 466-2800

MAVIS A. WALTERS
SENIOR VICE PRESIDENT

RECEIVED
JUL 15 1986
Ways and Means
Subcommittee on Oversight

July 15, 1986

The Honorable J.J. Pickle
Chairman, Subcommittee on Oversight
Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairman Pickle:

We are pleased to provide this additional information to the Subcommittee on Oversight as requested in your letter of June 5, 1986.

As a non-profit statistical agent and rate service organization for property-casualty insurance companies, we provide a great deal of information routinely to participating insurers. In addition, we conduct special studies and research projects in order to fulfill our responsibility to periodically inform the property/casualty insurance industry, its regulatory authorities and other interested parties about significant problems and difficulties which we may have identified.

Enclosed, please find the following material corresponding directly to the items listed in your June 5 letter:

1) Insurance rates for almost all property-casualty lines are determined on a state by state basis. A company which chooses to participate for our advisory rate service will specify the line or lines of insurance as well as the state or states for which they desire that service. For illustrative purposes, we have chosen general liability lines in Arkansas as the example for which a company receives an advisory rate manual. The enclosed package includes the countrywide rules and classification definitions for general liability accompanied by the individual rate pages for Arkansas.

2) Companies who use ISO as a statistical agent record and report their commercial lines premium and loss information in accordance with the detailed instructions specified in our Commercial Statistical Plan.

A copy of the full plan is attached.

3) ISO distributes price activity circulars which inform participating insurers of the cumulative rate level increases or decreases filed by ISO in each state for each of sixteen lines of insurance. We have included the pages for general liability (owners, landlords & tenants, manufacturers and contractors, and products liability), Hospital Professional Liability and Physicians, Surgeons and Dentists (medical malpractice) for each of the years 1981-1985.

4) A.M. Best publishes industrywide financial results which they compile from insurer annual statements. Enclosed is an updated report dated April 7, 1986 detailing final 1985 results for the property-casualty insurance industry based on the A.M. Best compilation.

5) Each quarter ISO publishes a circular presenting consolidated operating results for the entire property/casualty industry based on the experience of insurer groups that report to ISO and NAII (National Association of Independent Insurers). Enclosed is the First-Quarter 1986 analysis based on an estimated 97% of the total industry premium.

6) ISO updated the data for selected classes in April, 1986 which includes premium and loss data for the following:
   - Owners,Landlords Tenants
   - Municipal Classes
   - Streets and Roads
   - Public Schools
   - Governmental Subdivisions
   - Municipal Related Classes
   - Recreational Classes
   - Day Nurseries
   - Liquor Liability

A copy of countrywide results is enclosed.

7) As indicated previously, insurers receive advisory rates on a state by state basis. We have again chosen Arkansas for illustrative purposes and have enclosed a circular announcing revised basic limit rates for premises and operations classifications (O. L. & T.) effective August, 1985.

8) We have attached a list of known closed claim studies conducted by various industry groups over the last fifteen years.

9) A copy of highlights document and the full report of the Product Liability Closed Claim Study, which was done by ISO, is attached.

10) ISO has recently conducted a study on insurer defense costs entitled, "The Rising Costs of General Liability Legal Defense", a copy of which is attached. For additional information in this regard we refer you to the Institute for Civil Justice at the Rand Corporation.

11) Information on claims and losses involving day care centers is included in the response to Questions # 6.

12) A.M. Best and Company is an independent business corporation which routinely compiles property-casualty financial data both in the aggregate and by individual company and would be the best source for this information. ISO does not capture financial information by individual company and, therefore, cannot provide you with an analysis of the ten largest firms.

13) We have requested responses to the last questions from each of the trade associations copied on your letter. Attached is the information received. In addition we are attaching a copy of a study entitled, "The Need for Legislative Reform of the Tort System".

Sincerely,

Mavis A Walters

Mavis A. Walters
Senior Vice President

MAW:tmp
Encl.

*Item #1: Advisory Rate Guidelines

*Item #2: Commercial Statistical Plan

Item #3: Rate level history for General Liability and Medical Malpractice

Item #4: Year-end 1985 Operating Results

Item #5: Collective financial data sent to companies

Item #6: Special project on "experience data by lines of insurance"

Item #7: "Advisory Rate" Package

Item #8: Closed-claim information

**Item #9: ISO product-liability closed claim survey

*Item #10: ISO studies regarding property-casualty litigation

Item #11: Day Care Centers - premium and loss information

*Item #13: Attachments from trade associations on availability problems in certain lines of insurance.

NOTE TO READER:

* Because of the length of these materials, data was not included in the printer record, but will be maintained in the Subcommittee files.

** Highlights included, Technical Analysis of Survey in the Subcommittee files.

ITEM #3:

RATE LEVEL HISTORY FOR GENERAL LIABILITY AND MEDICAL MALPRACTICE

OWNERS, LANDLORDS & TENANTS

1981 RATE LEVEL REVISIONS **THROUGH FOURTH QUARTER**

	INCREASED LIMITS				BASIC RATE LEVEL CHANGE				
STATE	EFF. DATE	B.I.	EFF. DATE	P.D.	EFF. DATE	B.I.	P.D.	COMBINED TOTAL LIMITS	PENDING BASIC B.I.
Alabama					9/1	+12.0%		+ 9.8%	
Alaska	11/1	+ 7.6%			11/1	+11.7		+18.5	
Arizona	9/1	+ 7.6			9/1	+28.8		+34.9	
Arkansas	9/1	+ 7.6			9/1	+27.2		+32.4	
California	9/1	+ 7.6			9/1	+ 3.0		+ 9.7	
(e) Colorado	9/1	+ 7.6			9/1	+32.[illegible]		+37.1	
Connecticut	10/1	+ 7.6						+ 7.0	
Delaware									+ 27.1%
Dist. of Col.									+ 19.7
Florida					4/1	+15.5		+14.4	+ 14.9(c)
Georgia	9/1	+ 7.6						+ 6.5	
Idaho	9/1	+ 7.6			9/1	+17.1		+21.7	
(d) Illinois					7/28				
Indiana	9/1	+ 7.6			9/1	+15.8		+21.7	
Iowa					1/1,12/1	+67.3(f)		+60.4	
Kansas					1/1	+21.0(b)		+17.8	+ 25.3(c)
Kentucky									+ 50.1
Louisiana					4/1	+40.7(b)		+36.1	
Maine					5/1	+12.7(b)		+11.6	+ 24.8(b)
Maryland	12/1	+ 7.6			3/1,12/1	+31.9(f)		+37.1	
Massachusetts									
Michigan	10/1	+ 7.6			10/1	+ 5.9		+12.8	
Minnesota	9/1	+ 7.6			9/1	+ 5.5		+12.5	
Mississippi									+ 4.8
Missouri	9/1	+ 7.6			9/1	+18.9		+25.7	
Montana	9/1	+ 7.6			9/1	+20.1		+25.1	
Nebraska									+ 12.6
Nevada					5/1	+20.0(b)		+17.9	+ 71.3
New Hampshire	11/1	+ 7.6			11/1	+25.0(b)		+34.5	
New Jersey									+ 64.5(g)
New Mexico	9/1	+ 7.6			9/1	+ 9.8		+15.5	
(e) New York	11/1	+ 7.6			11/1	+10.1		+16.3	
North Carolina	10/1	+ 7.6			10/1	+22.9		+27.1	
North Dakota	10/1	+ 7.6			4/1,10/1	+55.7(f)		+51.8	
Ohio	9/1	+ 7.6			9/1	+ 3.8		+10.6	
Oklahoma					4/1	+ 8.3(b)		+ 7.5	+73.9
Oregon	9/1	+ 7.6			9/1	+25.6		+31.2	
Pennsylvania					2/1	+10.9(b)		+ 9.8	
Puerto Rico	11/1	+ 7.6						+ 6.8	+ 20.4(b)
Rhode Island					9/1	+21.8(b)		+19.6	
South Carolina					6/1	+32.7(b)		+28.2	
South Dakota	12/1	+ 7.6			12/1	+24.3		+28.5	
Tennessee									+ 21.8
Texas					12/1	+13.8		+12.1	
Utah	9/1	+ 7.6			9/1	+16.4		+22.4	
Vermont									+ 55.4
(e) Virginia	9/1	+ 7.6			9/1	+36.1		+40.4	
Washington	12/14	+ 7.6			12/14	+13.7		+19.7	
West Virginia	12/1	+11.4						+ 9.6	
Wisconsin	9/1	+ 7.6			9/1	+33.8		+40.5	
Wyoming									
(a) ISO SUB-TOTAL								+14.6	
Hawaii					9/1	+43.3		+37.7	
OTHER BUREAU SUB-TOTAL								+37.7	
(a) ALL STATES TOTAL								+14.9	

(a) Excludes Illinois.
(b) Original Filing Amended.
(c) Approved Effective First Quarter 1982.
(d) Adjusted Loss Costs Information. Date is circular release.
(e) Staff Developed Rates. Date is manual edition date.
(f) Combined Effect of Two Filings Effective in 1981.
(g) Withdrawn.

OWNERS, LANDLORDS & TENANTS

1982 RATE LEVEL REVISIONS THROUGH FOURTH QUARTER

	STATE	INCREASED LIMITS EFF. DATE	INCREASED LIMITS B.I.	INCREASED LIMITS EFF. DATE	INCREASED LIMITS PD	BASIC RATE LEVEL CHANGE EFF. DATE	BASIC RATE LEVEL CHANGE B.I.	BASIC RATE LEVEL CHANGE P.D.	COMBINED TOTAL LIMITS	PENDING BASIC B.I.
	Alabama	6/1	+7.6%			12/15	+20.0%(b)		+25.8%	
	Alaska					12/15	+16.6		+15.2	
	Arizona					10/1	+26.7		+23.6	
	Arkansas									
	California					10/1	+28.6		+26.0	
	Colorado									
	Connecticut					12/15	+17.4		+16.0	
	Delaware	7/1	+11.4						+10.2	+58.9
	Dist. of Col.	6/1	+ 7.6			6/1	+ 6.9(b)		+13.3	
	Florida	3/1	+ 7.6			3/1,12/21	+48.9(g)		+47.3	
	Georgia					12/15	+30.0		+26.7	
	Idaho					10/1	+13.6		+11.2	
(f)	Illinois					8/12				
	Indiana					11/1	+15.4		+13.7	
	Iowa	1/1	+ 7.6			12/1	+13.0		+18.9	
	Kansas	2/1	+ 7.6			2/1	+25.3		+29.7	
(e)	Kentucky					12-82	+20.0		+17.7	
	Louisiana									+33.0
	Maine					5/1	+24.8(b)		+24.2	+26.1
	Maryland					12/15	+35.0		+30.3	
	Massachusetts									
	Michigan					10/1	+11.6		+11.1	
	Minnesota					10/1	+40.0		+35.5	
	Mississippi	10/1	+ 7.6			10/1	+25.0		+31.8	
	Missouri					10/1	+ 6.1		+ 5.7	
	Montana									
	Nebraska									+30.0
	Nevada					6/1	+18.4(b)		+16.1	+57.5
	New Hampshire					12/1	+20.0(b)		+18.8	
	New Jersey	4/1	+11.4			7/15	+34.8(b)		+47.0	
	New Mexico					12/1	+26.8		+23.7	
(e)	New York					10-82	+25.0		+22.7	
	North Carolina									
	North Dakota					11/1	+24.8		+19.9	
	Ohio					10/1	+35.0		+30.3	
	Oklahoma	6/1	+11.4			6/1	+26.8(b)		+35.8	
	Oregon					11/1	+25.0		+21.7	
	Pennsylvania	9/1	+7.6			9/1	+15.7(b)		+24.5	
	Puerto Rico					6/1	+20.4(b)		+17.8	+25.5
	Rhode Island									+77.4
	South Carolina					8/1	+30.0(b)		+25.8	
	South Dakota									
	Tennessee									
	Texas	6/1	+11.4						+10.7	+ 8.3(b)(c)
	Utah									
	Vermont	9/1	+7.6			9/1	+15.7(b)		+20.9	
(e)	Virginia					11-82	+20.0		+16.6	
	Washington					11/1	+15.0		+12.9	
	West Virginia					8/1	+39.7		+33.0	
	Wisconsin					10/1	+14.6		+14.0	
	Wyoming									
(a)	ISO SUB-TOTAL								+21.1	
	Hawaii	3/1	13.1(b)						+12.2	+19.9
	OTHER BUREAU SUB-TOTAL								+12.2	
(a)	ALL STATES TOTAL								+21.0	

(a) Excludes Illinois.
(b) Original Filing Amended.
(c) Scheduled for Implementation or Approved Effective First Quarter 1983.
(d) Previous filing withdrawn.
(e) Staff Developed Rates. Date is manual edition date.
(f) Adjusted Lost Costs Information. Date is circular release.
(g) Combined Effect of Two Filings Effective in 1982.

OWNERS, LANDLORDS & TENANTS

1983 RATE LEVEL REVISIONS THROUGH FOURTH QUARTER

	STATE	INCREASED LIMITS EFF. DATE	INCREASED LIMITS B.I.	BASIC RATE LEVEL CHANGE EFF. DATE	BASIC RATE LEVEL CHANGE B.I.	COMBINED TOTAL LIMITS	PENDING BASIC B.I.
	Alabama			12/31	+20.0%(b)	+16.8%	
	Alaska						
	Arizona			10/1	-10.0	- 8.4	
	Arkansas			10/1	+11.1	+ 7.8	
(e)	California			10-83	+ 7.0	+ 5.7	
(g)	Colorado			10-83	- 5.8	- 4.8	
	Connecticut			12/15	+20.0	+17.8	
	Delaware			5/1	+20.0(b)	+16.5	
	Dist. of Col.			10/1	+20.0(b)	+14.6	
	Florida			12/21	+ 8.8	+ 7.7	
	Georgia			12/15	+20.3	+17.3	
(e)	Idaho			10-83	+14.8	+11.5	
(d)	Illinois			7/7			
	Indiana						
	Iowa			11/1	-20.0	-15.2	
	Kansas						
	Kentucky						
	Louisiana			8/1	+14.9	+13.0	
	Maine			5/1	+15.0(b)	+12.4	+12.0%(b)(c)
	Maryland			12/15	+ 6.7	+ 5.7	
	Massachusetts						
	Michigan			11/1	+30.0	+27.2	
	Minnesota						
	Mississippi						+12.0(b)(c)
	Missouri			10/1	-10.0	- 9.0	
	Montana			10/1	- 7.0	- 5.5	
	Nebraska						+30.0
	Nevada			9/1	+28.7(b)	+23.8	
	New Hampshire			12/1	+11.0(b)	+ 9.9	
	New Jersey			8/1	+30.0	+26.6	
	New Mexico						
(g)	New York			10-83	+18.9	+15.7	
	North Carolina			10/1	+15.0	+12.4	
	North Dakota						
	Ohio			10/1	+10.2	+ 8.9	
	Oklahoma			9/1	+25.0(b)	+20.7	
	Oregon			10/1	+10.4	+ 9.2	
	Pennsylvania			10/15	+35.0(b)	+29.5	
	Puerto Rico						
	Rhode Island						+116.2
	South Carolina			10/1	+15.0(b)	+12.5	
	South Dakota			10/1	+12.1	+ 8.8	
	Tennessee	12/31	+7.7%	12/31	+15.0	+17.8	
	Texas			1/1	+ 8.3(b)	+ 7.2	
	Utah			10/1	+ 6.6	+5.6	
	Vermont			11/1	+26.7	+22.2	
(f)	Virginia			10/1	-10.0	- 7.6	
	Washington			11/1	+15.0	+12.7	
	West Virginia			10/1	+23.8(b)	+18.9	
	Wisconsin			10/1	-12.9	-11.3	
(g)	Wyoming	12-83	+7.7%	10-83	+20.0	+22.4	
(a)	ISO SUB-TOTAL					+10.3%	
	Hawaii			2/1	+14.7(b)	+12.7%	+17.9
	OTHER BUREAU SUB-TOTAL					+12.7%	
(a)	ALL STATES TOTAL					+10.3%	

(a) Excludes Illinois.
(b) Original Filing Amended.
(c) Scheduled for Implementation or Approved Effective First Quarter 1984.
(d) Adjusted Loss Costs Information. Date is circular release.
(e) Date is manual edition date.
(f) Staff Developed Rates.
(g) Staff Developed Rates. Date is manual edition date.

OWNERS, LANDLORDS & TENANTS

1984 RATE LEVEL REVISIONS THROUGH FOURTH QUARTER

		INCREASED LIMITS		BASIC RATE LEVEL CHANGE		COMBINED TOTAL LIMITS	PENDING BASIC B.I.
	STATE	EFF. DATE	B.I.	EFF. DATE	B.I.		
	Alabama						+32.5%(c)
	Alaska			12/31	+26.8%	+23.4%	
	Arizona			10/1	+15.0	+12.4	
	Arkansas			10/1	+13.7	+11.6	
(e)	California			10-84	+23.4	+20.6	
(g)	Colorado			10-84	+11.5	+ 9.6	
	Connecticut						
	Delaware			12/31	+ 5.1	+ 4.4	
	Dist. of Col.			12/15	+25.0(b)	+21.9	
	Florida			12/31	+14.1(b)	+12.5	
	Georgia			12/15	+30.0	+25.7	
(e)	Idaho			10-84	+15.0	+12.1	
(d)	Illinois			9/24			
	Indiana			11/1	+24.5	+21.6	
	Iowa			10/1	-11.0	- 9.4	
	Kansas						+11.4(i)
(d)	Kentucky	2/17	+11.6%	10/15	+13.6	+22.6	
	Louisiana			12/31	+25.0	+21.4	
	Maine	5/1	+7.2	5/1	+12.0(b)	+18.4	
	Maryland			12/15	+28.0	+23.9	
	Massachusetts	1/1	+ 7.7	10/1	+30.0	+39.1	
	Michigan			11/1	+ 4.3	+ 3.9	
	Minnesota			11/1	+25.9	+22.6	
	Mississippi			2/1	+12.0(b)	+10.8	+12.9(c)
	Missouri			11/1	+30.0	+26.7	
	Montana			11/1	+13.9	+11.9	
	Nebraska			4/1	+10.0(b)	+ 8.5	+26.7(i)
	Nevada	3/1	+11.6			+ 9.6	+40.0
	New Hampshire			12/31	+ 6.1	+ 5.6	
	New Jersey			11/1	+35.0	+31.3	
	New Mexico			11/1	+17.2	+14.5	
(g)	New York			11-84	+22.0	+19.8	
	North Carolina			10/1	+17.1	+14.4	
	North Dakota			12/1	+ 7.9	+ 6.4	
	Ohio			10/1	+21.8	+19.2	
	Oklahoma						
	Oregon			10/1	+ 5.5	+ 4.8	
	Pennsylvania			12/1	+25.0	+21.8	
	Puerto Rico						+25.0
	Rhode Island	5/1	+11.6	5/1	+68.0(b)	+73.2	
	South Carolina						+31.9
	South Dakota						
(g)	Tennessee			11/1	+25.0	+21.2	
	Texas			12/1	+12.1	+10.4	
	Utah			11/1	+30.0	+25.1	
	Vermont			11/1	+25.0	+21.7	
(f)	Virginia			10/1	+16.4	+14.1	
	Washington			12/31	+25.0	+21.0	
	West Virginia						+42.2(i)
	Wisconsin						
(g)	Wyoming			10/31	+37.3	+29.5	
(a)	ISO SUB-TOTAL					+16.9	
	Hawaii			2/1	+12.5(b)	+10.9	
	OTHER BUREAU SUB-TOTAL					+10.9	
(a)	ALL STATES TOTAL					+16.8	

(a) Excludes Illinois.
(b) Original Filing Amended.
(c) Scheduled for Implementation or Approved Effective First Quarter 1985.
(d) Staff Developed Loss Costs. Date is circular release.
(e) Date is manual edition date.
(f) Staff Developed Rates.
(g) Staff Developed Rates. Date is manual edition date.
(h) Staff Developed Rates. Date is circular release.
(i) Disapproved.

OWNERS, LANDLORDS & TENANTS

1985 RATE LEVEL REVISIONS

THROUGH FOURTH QUARTER

	STATE	INCREASED LIMITS EFF. DATE	INCREASED LIMITS B.I.	BASIC RATE LEVEL CHANGE EFF. DATE	BASIC RATE LEVEL CHANGE B.I.	BI & PD COMBINED TOTAL LIMITS	PENDING BASIC LIMITS B.I.	PENDING INCREASED LIMITS B.I.
	Alabama	4/1	+15.3%	1/15	+32.5%	+43.7%		
	Alaska	4/1	+15.3	9/1	+25.1	+39.3		
	Arizona	3/1	+15.3	8/1	+25.0	+37.7		
	Arkansas	3/1	+15.3	8/1	+ 6.9	+20.1		
(a)	California	3-85	+15.3	8-85	+35.0	+48.7		
(a)	Colorado	3-85	+15.3	8-85	+35.0	+46.4		
	Connecticut	6/1	+15.3	11/1	+20.9	+35.5		
	Delaware			12/31	+20.0(d)	+17.1		
	Dist. of Col.	9/1	+15.3	12/15	+28.0	+41.6		+18.0%
	Florida	5/1	+15.3	12/31	+14.7	+28.0		
	Georgia	4/1	+15.3	12/15	+ 8.7	+21.4		
(a)	Idaho	3-85	+15.3	8-85	+17.6	+29.2		
(b)	Illinois	3-85(a)	+15.3	7/27	+ 9.9	+23.9		
	Indiana	3/1	+15.3	8/1	+25.0	+38.2		
	Iowa	4/1	+15.3	9/1	+35.0	+48.4		
	Kansas	8/1	+15.3	8/1	+11.4(d)	+23.4		
(b)	Kentucky	3-85(a)	+15.3	7/31	+20.4	+32.2		
	Louisiana	5/1	+14.9	12/31	+27.0	+39.8		
	Maine	7/1	+16.4	9/1	+20.0	+35.0		
	Maryland	3/1	+15.3	8/1	+31.2	+43.6		
	Massachusetts	3/1	+15.3			+13.7		
	Michigan	3/1	+15.3	8/1	+37.4	+52.4		
	Minnesota	3/1	+15.3	8/1	+25.0	+39.3		
	Mississippi	11/1	+ 6.8	2/1	+12.9	+16.1		
	Missouri	3/1	+15.3	8/1	+23.3	+36.7		
	Montana	3/1	+15.3	8/1	+37.6	+49.1		
	Nebraska	12/1	+15.4			+12.9		
	Nevada	7/1	+15.3	4/1	+31.4(b)	+43.2		
	New Hampshire	9/1	+15.3			+13.7		
	New Jersey	3/1	+15.3	10/1	+25.0	+39.3		
	New Mexico	3/1	+15.3	8/1	+20.0	+31.4		
(a)	New York	3-85	+15.3	12/1	+23.2	+37.5		
	North Carolina	3/1	+15.3	10/1	+25.0	+37.0		
	North Dakota	6/1	+15.3	10/1	+17.9	+29.4		
	Ohio	3/1	+15.3	8/1	+15.8	+29.1		
	Oklahoma	9/1	+18.0			+15.3		
	Oregon	3/1	+15.3	8/1	+30.0	+43.4		
	Pennsylvania	10/1	+15.3	12/31	+18.6(d)	+31.1		
	Puerto Rico			12/31	+25.0			
	Rhode Island							+13.3(c)
	South Carolina	4/1	+ 9.5	6/1	+23.9(d)	+30.6		
	South Dakota	7/1	+15.3	12/1	+15.0	+27.6		
	Tennessee	7/1	+15.3			+12.7	+29.8%(e)	
	Texas	12/31	+15.3	12/31	+30.0	+41.8		
	Utah	3/1	+15.3	8/1	+ 3.4	+16.7		
	Vermont	3/1	+15.3	11/1	+27.1	+38.9		
	Virginia	3/1	+15.3	8/1	+20.0	+32.5		
	Washington	3/1	+15.3	10/1	+35.0	+47.6		
	West Virginia	3/1	+15.3	6/1	+42.2	+50.7		
	Wisconsin	3/1	+15.3	8/1	+20.0	+33.9		
(b)	Wyoming	3-85(a)	+15.3	7/31	+26.5	+36.3		
	ISO SUB-TOTAL					+35.6		
	Hawaii	3/1	+15.3	7/1	+25.0	+39.4		
	OTHER BUREAU SUB-TOTAL					+39.4		
	ALL STATES TOTAL					+35.7		

(a) Date is manual edition date.
(b) Loss Costs. Date is circular release.
(c) Scheduled for Implementation or Approved Effective First Quarter 1986.
(d) Original Filing Amended.
(e) Disapproved.

MANUFACTURERS & CONTRACTORS LIABILITY

1981 RATE LEVEL REVISIONS THROUGH FOURTH QUARTER

	INCREASED LIMITS			BASIC RATE LEVEL CHANGE				PENDING BASIC	
STATE	EFF. DATE	B.I.	P.D.	EFF. DATE	B.I.	P.D.	COMBINED TOTAL LIMITS	B.I.	P.D.
Alabama	6/1	+ 4.2%	-10.3%	6/1	+13.5%(b)	- 5.2%	+ 7.5%		
Alaska									
Arizona									
Arkansas									
California									
Colorado									
Connecticut								- 5.3%	- 7.2%
Delaware	3/1	+ 4.2	-10.3	3/1	+10.0	- 5.0	+ 2.9		
Dist. of Col.									
Florida	9/1	+ 4.2	+10.3	9/1	+17.0	- 7.7	+ 9.9		
Georgia									
Idaho				5/1	-10.0	-10.0	-10.0		
(d)Illinois				7/27					
Indiana									
Iowa									
Kansas								+ 0.0	+11.1(b)(c)
Kentucky									
Louisiana									
Maine									
Maryland									
Massachusetts								+10.0	- 5.0
Michigan									
Minnesota				5/1	-10.0	0.0	- 6.7		
Mississippi									
Missouri				6/1	+15.0	0.0	+ 9.1		
Montana									
Nebraska	5/1	+ 4.2	-10.3	5/1	+ 5.0	+ 6.0	+ 3.4		
Nevada				8/1	0.0	0.0	0.0(b)		
New Hampshire									
New Jersey	5/1	+ 4.2	-10.3				+ 0.5		
New Mexico									
New York									
North Carolina									
North Dakota	4/1	+ 4.2	-10.3				- 3.6		
Ohio									
Oklahoma	4/1	+ 4.2	+ 5.0				+ 4.5	+25.0	0.0(e)
Oregon				5/1	+10.0	0.0	+ 6.9		
Pennsylvania	3/1	+ 4.2	-10.3	3/1	0.0	+15.0(b)	+ 3.9		
Puerto Rico								+10.0	-10.0(e)
Rhode Island									
South Carolina								+25.5	+18.4
South Dakota				6/1	+10.4	+24.2	+16.7		
Tennessee								+ 3.3	+ 8.8
Texas								- 4.4	+ 2.2(f)
Utah									
Vermont									
Virginia									
Washington									
West Virginia								0.0	+12.7(b)
Wisconsin				5/1	-10.0	- 5.0	- 8.2		
Wyoming									
(a)ISO SUB-TOTAL							+ 0.6		
Hawaii				6/1	+ 2.2	- 8.0	- 2.7		
OTHER BUREAU SUB-TOTAL							- 2.7		
(a)ALL STATES TOTAL							+ 0.6		

(a) Excludes Illinois.
(b) Original Filing Amended.
(c) Approved Effective First Quarter 1982.
(d) Adjusted Loss Costs Information. Date is circular release.
(e) Withdrawn.
(f) Previous Filing Withdrawn.

MANU[illegible]RS & CONTRACTORS LIABILITY

[illegible]2 RATE LEVEL REVISIONS THROUGH FOURTH QUARTER

		INCREASED LIMITS			BASIC RATE LEVEL CHANGE				PENDING BASIC	
	STATE	EFF. DATE	B.I.	P.D	EFF. DATE	B.I.	P.D.	COMBINED TOTAL LIMITS	B.I.	PD
	Alabama									
	Alaska				4/1	-10.0%	-15.0%	-11.0%		
	Arizona				3/1	+ 3.5	+14.9	+ 6.9		
	Arkansas				3/1	+16.6	+32.4	+22.9		
	California				3/1	-15.0	+ 8.3	- 9.4		
(c)	Colorado				3-82	[illegible]0.0	+35.0	+ 4.8		
	Connecticut				4/1	- 5.3	- 7.2	- 6.1		
	Delaware									
	Dist. of Col.								-6.3%	+35.0%
	Florida									
	Georgia				3/1	-10.0	0.0	- 6.0		
	Idaho				3/1	+15.0	+30.0	+20.8		
(d)	Illinois				2/23					
	Indiana				3/1	0.0	+16.7	+ 5.5		
	Iowa				5/1	- 0.2	+11.8	+ 4.0		
	Kansas	1/1	+12.5%	-10.3%	1/1	0.0(b)	+11.1	+ 6.7		
	Kentucky									
	Louisiana				8/1	+8.8	+4.8	+ 7.9		
	Maine									
	Maryland				6/1	+25.8	+ 4.9	+15.5		
	Massachusette									
	Michigan									
	Minnesota				3/1	-16.0	+13.2	- 5.4		
	Mississippi				10/1	-15.0	0.0	- 9.8		
	Missouri				4/1	+12.5	+ 3.3	+ 9.1		
	Montana				3/1	0.0	+15.0	+ 6.6		
	Nebraska				4/1	-10.2	+ 7.4	- 1.5		
	Nevada									
	New Hampshire				6/1	0.0(b)	+15.2(b)	+ 6.7		
	New Jersey									
	New Mexico				3/1	-15.0	0.0	-10.5		
(c)	New York				6-82	+ 3.5	+ 1.4	+ 2.9		
	North Carolina				3/1	-12.7	- 8.0	-10.2		
	North Dakota				3/1	-12.9	+ 4.6	- 3.4		
	Ohio				3/1	-15.0	0.0	- 8.8		
	Oklahoma									
	Oregon				3/1	+ 3.7	+30.2	+11.9		
	Pennsylvania				7/1	0.0(b)	+ 8.6(b)	+ 3.0		
	Puerto Rico	2/1	+ 4.2	-10.3				- 0.3		
	Rhode Island									
	South Carolina	3/1	+12.5	+ 5.0	3/1	+18.0(b)	+11.0(b)	+26.2		
	South Dakota									
	Tennessee									
	Texas	6/1	+ 4.2	-10.3	6/1	- 4.4	+ 2.2	- 2.5		
	Utah				3/1	0.0	+25.0	+10.0		
	Vermont									
(c)	Virginia				3-82	0.0	+25.0	+12.6		
	Washington									
	West Virginia	2/1	+14.5	-10.3	2/1	0.0(b)	+12.7	+ 7.7		
	Wisconsin				3/1	-20.0	+ 7.4	-10.0		
	Wyoming									
(a)	ISO SUB-TOTAL							- 0.1		
	Hawaii									
	OTHER BUREAU SUB-TOTAL							0.0		
(a)	ALL STATES TOTAL							-0.1		

(a) Excludes Illinois.
(b) Original Filing Amended.
(c) Staff Developed Rates. Date is manual edition date.
(d) Adjusted Loss Costs Information. Date is circular release.

MANUFACTURERS & CONTRACTORS LIABILITY

1983 RATE LEVEL REVISIONS THROUGH FOURTH QUARTER

		INCREASED LIMITS			BASIC RATE LEVEL CHANGE			COMBINED TOTAL LIMITS	PENDING BASIC	
	STATE	EFF. DATE	B.I.	P.D	EFF. DATE	B.I.	P.D.		B.I.	P.D.
	Alabama	8/1	+ 5.3%	+ 4.8%	5/1	+ 7.9%	+20.0%	+17.3%		
	Alaska	8/1	+ 5.3	+ 4.8	6/1	+ 2.6	- 4.9	+ 5.9		
	Arizona	8/1	+ 5.3	+ 4.8	4/1	+ 4.9	+20.0	+15.2		
	Arkansas	8/1	+ 5.3	+ 4.8	4/1	-11.6	+18.8	+ 5.6		
(e)	California	8-83	+ 5.3	+ 4.8	5-83	+14.3	+25.0	+23.1		
(f)	Colorado	8-83	+ 5.3	+ 4.8	5-83	0.0	+17.1	+12.4		
	Connecticut	8/1	+ 5.3	+ 4.8	6/1	+ 1.7	+25.0	+16.5		
	Delaware	10/1	+ 5.3	+ 4.8	9/1	+10.0 (d)	+10.0 (d)	+15.6		
	Dist. of Col.	9/1	0.0	0.0	9/1	+ 5.0 (d)	+32.0 (d)	+15.0		
	Florida	10/1	+ 5.3	+ 4.8	8/1	+15.0	+30.0	+25.6		
	Georgia	8/1	+ 5.3	+ 4.8	5/1	+ 6.5	+20.0	+18.1		
(e)	Idaho	8-83	+ 5.3	+ 4.8	4-83	+ 0.7	+10.0	+ 9.6		
(c)	Illinois				2/18					
	Indiana	8/1	+ 5.3	+ 4.8	4/1	+11.4	+17.9	+19.7		
	Iowa	8/1	+ 5.3	+ 4.8	5/1	- 3.4	+25.0	+11.2		
	Kansas	8/1	+ 5.3	+ 4.8	7/1	- 4.5	+35.0	+19.7		
(e)	Kentucky	8-83	+ 5.3	+ 4.8				+ 5.1		
	Louisiana								-0.0(d)%	+0.0(d)%
	Maine				5/1	+ 3.0	- 2.2	+ 0.2		
	Maryland	8/1	+ 5.3	+ 4.8	5/1	- 1.8	+20.0	+13.5		
	Massachusetts	8/1	+ 5.3	+ 4.8				+ 5.1		
	Michigan	8/1	+ 5.3	+ 4.8	4/1	+ 9.9	+30.0	+21.2		
	Minnesota	8/1	+ 5.3	+ 4.8	5/1	+ 5.5	+20.0	+16.9		
	Mississippi	9/1	+ 5.3	+ 4.8				+ 5.1		
	Missouri	8/1	+ 5.3	+ 4.8	5/1	- 0.3	+16.4	+11.2		
	Montana	8/1	+ 5.3	+ 4.8	5/1	+ 5.8	+25.0	+19.6		
	Nebraska									
	Nevada	11/1	+30.0	-15.4				+13.2	+ 4.2	+25.1(d)
	New Hampshire				6/1	+ 2.0(d)	+14.0(d)	+ 7.2		
	New Jersey	8/1	+ 5.3	+ 4.8	8/1	+20.0	+15.0	+24.4		
	New Mexico	8/1	+ 5.3	+ 4.8	5/1	-15.0	+30.0	+ 5.3		
	New York	6/30	+ 5.3	+ 4.8	6/30	+20.0	+20.0	+26.2		
	North Carolina	8/1	+ 5.3	+ 4.8	5/1	+20.0	+20.0	+26.1		
	North Dakota	8/1	+ 5.3	+ 4.8	4/1	-10.0	+15.0	+ 9.4		
	Ohio	8/1	+ 5.3	+ 4.8	5/1	+30.0	+30.0	+36.6		
	Oklahoma									
	Oregon	8/1	+ 5.3	+ 4.8	5/1	- 9.1	+23.8	+ 7.0		
	Pennsylvania	10/15	+ 5.3	+ 4.8	10/15	+20.0(d)	+35.0(d)	+31.7		
	Puerto Rico								+15.0	+10.0
	Rhode Island				12/1	+15.0(d)	+28.0(d)	+20.5		
	South Carolina	11/1	+ 5.3	+ 4.8				+ 5.1		
	South Dakota	8/1	+ 5.3	+ 4.8	5/1	-11.3	+30.0	+13.0		
	Tennessee								+ 1.2	+25.7
	Texas	12/1	+ 5.3	+ 4.8	12/1	+13.8(d)	+25.0(d)	+23.7		
	Utah	8/1	+ 5.3	+ 4.8	5/1	- 4.8	+35.0	+19.1		
	Vermont	11/1	+ 5.3	+ 4.8	10/1	+18.5(d)	+12.1(d)	+20.9		
(g)	Virginia	8/1	+ 5.3	+ 4.8	5/1	+12.1	+25.0	+25.1		
	Washington	8/1	+ 5.3	+ 4.8	4/1	+ 1.2	+25.0	+14.1		
	West Virginia	9/1	+ 5.3	+ 4.8	10/1	+21.5(d)	+24.6(d)	+29.3		
	Wisconsin	8/1	+ 5.3	+ 4.8	5/1	+15.0	+18.7	+22.4		
	Wyoming									
(a)	ISO SUB-TOTAL							+18.4%		
	Hawaii								+16.0(d)	+22.0(b)(d)
	OTHER BUREAU SUB-TOTAL							0.0		
(a)	ALL STATES TOTAL							+18.4%		

(a) Excludes Illinois.
(b) Scheduled for Implementation or Approved Effective First Quarter 1984.
(c) Adjusted Loss Costs Information. Date is circular release.
(d) Original Filing Amended.
(e) Date is manual edition date.
(f) Staff Developed Rates. Date is manual edition date.
(g) Staff Developed Rates.

MANUFACTURERS & CONTRACTORS LIABILITY

1984 RATE LEVEL REVISIONS THROUGH FOURTH QUARTER

		INCREASED LIMITS			BASIC RATE LEVEL CHANGE			COMBINED TOTAL LIMITS	PENDING BASIC	
	STATE	EFF. DATE	B.I.	P.D	EFF. DATE	B.I.	P.D.		B.I.	P.D.
	Alabama				7/1	+15.0%	+20.0%	+16.6%		
	Alaska									
	Arizona				5/1	+ 8.2	+10.2	+ 8.9		
	Arkansas				5/1	- 5.9	+ 2.3	- 1.9		
(e)	California				5-84	+23.3	+28.6	+24.8		
(f)	Colorado				5-84	+ 6.1	+35.0	+18.6		
	Connecticut				6/1	+30.0	+15.0	+23.6(d)		
	Delaware				6/1	0.0	+35.0	+12.1		
	Dist. of Col.	9/1	+6.2%	+4.1%	9/1	+25.3	+19.7	+30.0(d)		
	Florida				9/1	+30.0	+30.0	+30.0		
	Georgia				6/1	+21.5	+15.8	+18.8		
(e)	Idaho				5-84	+ 6.5	+ 4.1	+ 5.4		
(c)	Illinois				4/16					
	Indiana									
	Iowa				5/1	+15.8	+15.0	+15.5		
	Kansas				7/1	+10.3	+15.9	+13.5		
(c)	Kentucky				3/22	-12.7	+22.3	+ 3.4		
	Louisiana				11/1	+ 8.4	+35.0	+14.2		
	Maine	2/1	+ 6.7	+ 6.6	12/1	+11.0	0.0	+12.2(d)		
	Maryland				5/1	+15.0	+11.2	+13.1		
	Massachusetts				10/1	+40.0	+16.1	+30.0		
	Michigan				6/1	+27.3	+15.0	+23.7		
	Minnesota				5/1	+11.0	+20.0	+14.8		
	Mississippi				10/1	+ 7.0	+13.8	+ 9.5		
	Missouri									
	Montana				5/1	+ 8.4	+ 9.6	+ 9.0		
	Nebraska								0.0%	+20.0%(h)
	Nevada				8/1	0.0	+35.0	+11.3		
	New Hampshire	5/1	+ 5.3	+ 4.8	7/1	+10.0	+12.5	+16.9 (d)		
	New Jersey				8/15	+30.0	+10.0	+23.8		
	New Mexico				5/1	+ 5.9	+14.0	+ 9.4		
(f)	New York				6-84	+30.0	+10.0	+24.5		
	North Carolina				6/1	+20.0	+15.0	+17.4		
	North Dakota									
	Ohio				5/1	+16.9	+12.9	+15.1		
	Oklahoma	8/1	+ 5.3	+ 4.8	8/1	-15.0	0.0	- 3.3		
	Oregon									
	Pennsylvania				9/1	+28.3	+16.9	+23.9(d)		
	Puerto Rico									
	Rhode Island								+30.3	+43.9
	South Carolina								+11.1	+27.0
	South Dakota									
(f)	Tennessee	5-84	+21.4	-13.5	5-84	+15.0	+20.0	+22.9		
	Texas				12/1	+ 4.7	+25.0	+12.0		
	Utah				5/1	- 2.1	-10.0	- 6.2		
	Vermont				11/1	+ 4.4	+14.3	+ 9.9		
(g)	Virginia				5/1	+10.0	+10.0	+10.0		
	Washington				5/1	+ 3.0	+20.0	+ 8.7		
	West Virginia				11/1	+20.0	+40.0	+30.0		
	Wisconsin				5/1	+10.0	+ 8.3	+ 9.3		
(f)	Wyoming	1-84	+ 5.3	+ 4.8				+ 5.1		
(a)	ISO SUB-TOTAL							+16.2		
	Hawaii	5/1	+24.2	-15.4	1/1	+16.0(d)	+22.9(d)	+30.0		
	OTHER BUREAU SUB-TOTAL							+30.0		
(a)	ALL STATES TOTAL							+16.3		

(a) Excludes Illinois.
(c) Staff Developed Loss Costs. Date is circular release.
(d) Original Filing Amended.
(e) Date is manual edition date.
(f) Staff Developed Rates. Date is manual edition date.
(g) Staff Developed Rates.
(h) Schedule for Implementation or Approved Effective First Quarter 1985.

MANUFACTURERS & CONTRACTORS LIABILITY

1985 RATE LEVEL REVISIONS

THROUGH FOURTH QUARTER

	INCREASED LIMITS			BASIC RATE LEVEL CHANGE				PENDING		
STATE	EFF. DATE	B.I.	P.D.	EFF. DATE	B.I.	P.D.	COMBINED TOTAL LIMITS	BASIC LIMITS B.I.	BASIC LIMITS P.D.	INCREASED LIMITS (f)
Alabama	4/1	+ 7.4%	+ 9.5%	10/1	+40.0%(e)	+14.4%	+41.7%			
Alaska	4/1	+ 7.4	+ 9.5	4/1	- 0.8	+ 9.4	+ 9.5	- 1.1%	+31.0%	
Arizona	3/1	+ 7.4	+ 9.5	3/1	- 8.7	+23.1	+10.6	+30.7(c)	+34.5(c)	
Arkansas	3/1	+ 7.4	+ 9.5	3/1	0.0	+29.1	+24.1	+40.0(c)	+39.9(c)	
(a) California	3-85	+ 7.4	+ 9.5	3-85	+20.2	+55.2	+40.6			
(e) Colorado	3-85	+ 7.4	+ 9.5	3-85	-13.0	+ 8.2	+ 5.9	+ 6.1(c)	+25.0(c)	
Connecticut	6/1	+ 7.4	+ 9.5	7/1	+37.7	+34.7	+47.6			
Delaware				12/1	+10.3	+27.6(e)	+17.9			+8.1%
Dist. of Col.	9/1	+ 7.4	+ 9.5	9/1	+21.0(e)	+11.8(e)	+26.6			
Florida	5/1	+ 7.4	+ 9.5	11/1	+ 2.4	+16.5	+15.9			
Georgia	6/1	+ 7.4	+ 9.5	5/1	+11.6	+ 5.3	+17.4			
(a) Idaho	3-85	+ 7.4	+ 9.5	3-85	+ 8.3	+13.2	+19.6	+28.6(c)	+37.5(c)	
(b) Illinois	3-85(a)	+ 7.4	+ 9.5	3/27	- 4.6	+55.4	+12.9			
Indiana	3/1	+ 7.4	+ 9.5	3/1	+ 1.2	+28.4	+21.4	+10.8(c)	+30.5(c)	
Iowa	4/1	+ 7.4	+ 9.5	4/1	- 5.0	+14.9	+12.1	- 4.3(c)	+ 8.4(c)	
Kansas	8/1	+ 7.4	+ 9.5	8/1	+30.0(e)	+40.0(e)	+46.7	+28.7	+40.0	
(b) Kentucky	3-85(a)	+ 7.4	+ 9.5	3/27	- 0.5	+12.2	+14.7			
Louisiana	12/1	+23.1	- 9.2	12/1	+11.2	+ 2.4	+22.9			
Maine	7/1	+ 4.8	+ 9.8				+ 6.5			
Maryland	3/1	+ 7.4	+ 9.5	3/1	+29.1	+25.3	+37.5			
Massachusetts	5/1	+ 7.4	+ 9.5				+ 8.1	+35.0	+20.0	
Michigan	3/1	+ 7.4	+ 9.5	3/1	+40.0	+40.0	+51.3	+39.8(c)	+40.1(c)	
Minnesota	3/1	+ 7.4	+ 9.5	3/1	- 4.3	+15.2	+13.4	+ 9.2(c)	+12.2(c)	
Mississippi				12/1	+17.2	+ 6.4	+13.0			
Missouri	3/1	+ 7.4	+ 9.5	3/1	- 3.4	+34.7	+21.3	+ 0.6(c)	+24.8(c)	
Montana	3/1	+ 7.4	+ 9.5	4/1	+14.8	+27.8	+30.9	+33.4(c)	+32.4(c)	
Nebraska	12/1	+ 0.8	+11.4				+ 4.3	+ 7.5	+45.0	
Nevada	7/1	+ 7.4	+ 9.5				+ 8.1	+27.0	+45.0	
New Hampshire	9/1	+ 7.4	+ 9.5	9/1	+17.4(e)	+28.7(e)	+32.9			
New Jersey	5/1	+ 7.4	+ 9.5	10/1	+25.0	+10.0	+30.5			
New Mexico	3/1	+ 7.4	+ 9.5	3/1	- 5.3	+11.8	+10.2	+23.6(c)	+35.0(c)	
(a) New York	3-85	+ 7.4	+ 9.5	8-85	+30.0	+20.0	+37.8			
North Carolina	3/1	+ 7.4	+ 9.5	6/1	+15.0	+25.0	+29.8			
North Dakota	6/1	+ 7.4	+ 9.5	5/1	- 7.6	+ 8.9	+11.0	+ 8.4	+25.0	
Ohio	3/1	7.4	+ 9.5	3/1	+21.9	+16.0	+29.0	+31.9(c)	+33.5(c)	
Oklahoma	9/1	+ 7.4	+ 9.5				+ 8.1			
Oregon	3/1	+ 7.4	+ 9.5	3/1	+ 4.6	- 4.1	+ 7.7	+30.0(c)	+17.1(c)	
Pennsylvania	10/1	+ 7.4	+ 9.5	12/31	32.5(e)	+12.8(e)	+35.7			
Puerto Rico				12/1	+50.0	+50.0	+50.0			+15.9(g)(c)
Rhode Island				9/1	+15.0(e)	+21.0(e)	+17.6			
South Carolina				3/1	+11.1	+19.9(e)	+14.9			
South Dakota	7/1	+ 7.4	+ 9.5	6/1	+20.0	+30.0	+36.0			
Tennessee	8/1	+ 7.4	+ 9.5	8/1	- 6.7	+32.0	+18.7			
Texas	12/31	+ 7.4	+ 9.5	12/31	+25.3	+55.7	+48.1			
Utah	3/1	+ 7.4	+ 9.5	3/1	+35.0	+11.7	+34.0	+15.2(c)	+25.0(c)	
Vermont	3/1	+ 7.4	+ 9.5	11/1	+13.4	+10.2	+20.6			
Virginia	3/1	+ 7.4	+ 9.5	3/1	+23.9	+22.7	+33.2			
Washington	5/1	+ 7.4	+ 9.5	4/1	+12.5	+27.9	+28.1			
West Virginia	5/1	+ 7.4	+ 9.5	12/31	+ 5.8	+15.7	+20.3			
Wisconsin	3/1	+ 7.4	+ 9.5	3/1	+ 3.9	+ 5.7	+13.3	+14.3(c)	+20.0(c)	
(b) Wyoming	3-85(a)	+ 7.4	+ 9.5	3/29	+ 9.6	+26.8	+26.6			
ISO SUB-TOTAL							+29.6			
Hawaii	5/1	+ 7.4	+ 9.5				+ 8.1			
OTHER BUREAU SUB-TOTAL							+ 8.1			
ALL STATES TOTAL							+29.4			

(a) Date is manual edition date.
(b) Loss Costs. Date is circular release.
(c) Scheduled for Implementation or Approved Effective First Quarter 1986.
(d) 1984 Revision Withdrawn.
(e) Original Filing Amended.
(f) Countrywide Revision +8.1% (+7.4% B.I.; +9.5% P.D.).
(g) P.R. +15.9% (+16.1% B.I.; +15.5% P.D.)

PRODUCT LIABILITY

1981 RATE LEVEL REVISIONS THROUGH FOURTH QUARTER

STATE	INCREASED LIMITS EFF. DATE	B.I.	EFF DATE	P.D.	BASIC RATE LEVEL CHANGE EFF. DATE	B.I.	P.D.	COMBINED TOTAL LIMITS	PENDING BASIC B.I.	P.D.
Alabama									+ 8.0%	-19.4%(b)(d)
Alaska					6/1	-10.0%	-10.0%	-10.0%	+20.0	-10.4(b)
Arizona					6/1	-10.0	-10.0	-10.0	+20.0	-10.4(b)
Arkansas					6/1	-10.0	-10.0	-10.0	+20.0	-10.4(b)
California					6/1	-10.0	-10.0	-10.0	+20.0	-10.4(b)
(c)Colorado					6/1	-10.0	-10.0	-10.0	+20.0	-10.4(b)
Connecticut					8/1	-10.0	-10.0	-10.0	+20.0	-10.4
Delaware									+30.0	-19.4
Dist. of Col.					6/1	-10.0	-10.0	-10.0	+20.0	-10.4
Florida					6/1	-10.0	-10.0	-10.0	+20.0	-10.4(b)
Georgia					6/1	-10.0	-10.0	-10.0	+20.0	-10.4(b)
Idaho					6/1	-10.0	-10.0	-10.0	+20.0	-10.4(b)
Illinois										
Indiana					6/1	-10.0	-10.0	-10.0	+20.0	-10.4(b)
Iowa					8/1	-10.0	-10.0	-10.0	+20.0	-10.4(b)
Kansas					6/1	-10.0	-10.0	-10.0	+20.0	-10.4
Kentucky										
Louisiana									+62.4	- 5.3
Maine					6/1	-10.0	-10.0	-10.0		
Maryland					9/1	-10.0	-10.0	-10.0	+20.0	-10.4
Massachusetts										
Michigan					6/1	-10.0	-10.0	-10.0	+20.0	-10.4(b)
Minnesota					6/1	-10.0	-10.0	-10.0	+20.0	-10.4(b)
Mississippi					6/1	-10.0	-10.0	-10.0		
Missouri					6/1	-10.0	-10.0	-10.0	+20.0	-10.4(b)
Montana					6/1	-10.0	-10.0	-10.0	+20.0	-10.4(b)
Nebraska					7/1	-10.0	-10.0	-10.0	+20.0	-10.4
Nevada					7/1	-10.0	-10.0	-10.0	+20.0	-10.4
New Hampshire	9/1	+25.0%						+16.0		
New Jersey										
New Mexico					6/1	-10.0	-10.0	-10.0	+20.0	-10.4(b)
New York										
North Carolina										
North Dakota					7/1	-10.0	-10.0	-10.0	+20.0	-10.4
Ohio					6/1	-10.0	-10.0	-10.0	+ 20.0	-10.4 (b)
Oklahoma										
Oregon					6/1	-10.0	-10.0	-10.0	+20.0	-10.4(b)
Pennsylvania										
Puerto Rico					11/1	-10.0	-10.0	-10.0	+20.0	-10.4
Rhode Island										
South Carolina									+62.4	- 5.3
South Dakota					6/1	-10.0	-10.0	-10.0	+20.0	-10.4(b)
Tennessee					7/1	-10.0	-10.0	-10.0		
Texas									+ 8.0	-19.4
Utah					6/1	-10.0	-10.0	-10.0	+20.0	-10.4(b)
Vermont					6/1	-10.0	-10.0	-10.0	+20.0	-10.4
(c)Virginia					6/1	-10.0	-10.0	-10.0	+20.0	-10.4(b)
Washington					7/1	-10.0	-10.0	-10.0	+20.0	-10.4
West Virginia										
Wisconsin					6/1	-10.0	-10.0	-10.0	+20.0	-10.4(b)
Wyoming										
(a) ISO SUB-TOTAL								- 5.9		
Hawaii					7/1	-10.0	-10.0	-10.0		
OTHER BUREAU SUB-TOTAL								-10.0		
(a) ALL STATES TOTAL								- 5.9		

(a) Excludes Illinois.
(b) Approved Effective First Quarter 1982.
(c) Staff Developed Rates. Date is manual edition date.
(d) Previous Filing Withdrawn.

PRODUCT LIABILITY

1982 RATE LEVEL REVISIONS THROUGH FOURTH QUARTER

STATE	INCREASED LIMITS EFF. DATE	INCREASED LIMITS B.I.	INCREASED LIMITS EFF. DATE	INCREASED LIMITS P.D.	BASIC RATE LEVEL CHANGE EFF. DATE	BASIC RATE LEVEL CHANGE B.I.	BASIC RATE LEVEL CHANGE P.D.	COMBINED TOTAL LIMITS	PENDING BASIC B.I.	PENDING BASIC P.D.
Alabama					8/1	+ 8.0%	-19.4%	- 0.3%		
Alaska					3/1	+20.0	-10.4	+10.8		
Arizona					2/1	+20.0	-10.4	+10.8		
Arkansas					2/1	+20.0	-10.4	+10.8		
California					2/1	+20.0	-10.4	+10.8		
(b) Colorado					2-82	+20.0	-10.4	+10.8		
Connecticut					4/1	+20.0	-10.4	+10.8		
Delaware					10/1	+23.7(c)	- 5.1(c)	+15.0		
Dist. of Col.									+20.0%	-10.4%
Florida					3/1	+20.0	-10.4	+10.8		
Georgia					2/1	+20.0	-10.4	+10.8		
Idaho					2/1	+20.0	-10.4	+10.8		
Illinois										
Indiana					2/1	+20.0	-10.4	+10.8		
Iowa					2/1	+20.0	-10.4	+10.8		
Kansas					4/1	+20.0	-10.4	+10.8		
Kentucky										
Louisiana										
Maine					6/1	+20.0	-10.4	+10.8		
Maryland					9/1	+20.0	-10.4	+10.8		
Massachusetts										
Michigan					2/1	+20.0	-10.4	+10.8		
Minnesota					2/1	+20.0	-10.4	+10.8		
Mississippi					8/1	+20.0	-10.4	+10.8		
Missouri					2/1	+20.0	-10.4	+10.8		
Montana					2/1	+20.0	-10.4	+10.8		
Nebraska					8/1	+20.0	-10.4	+10.8		
Nevada					7/1	+20.0	-10.4	+10.8		
New Hampshire					12/31	+20.0(c)	- 0.9	+13.7		
New Jersey									+16.0	-5.3
New Mexico					2/1	+20.0	-10.4	+10.8		
New York										
North Carolina									+62.4	-5.3
North Dakota					6/1	+20.0	-10.4	+10.8		
Ohio					3/1	+20.0	-10.4	+10.8		
Oklahoma										
Oregon					2/1	+20.0	-10.4	+10.8		
Pennsylvania	11/1	-19.5%			11/1	+24.0	-5.3	-2.0		
Puerto Rico									+20.0	-10.4
Rhode Island										
South Carolina					12/1	+35.3(c)	-5.3	+23.0		
South Dakota					3/1	+20.0	-10.4	+10.8		
Tennessee					7/1	+20.0	-10.4	+10.8		
Texas					6/1	+ 8.0	-19.4	- 0.3		
Utah					2/1	+20.0	-10.4	+10.8		
Vermont					6/1	+20.0	-10.4	+10.8		
(b) Virginia					2-82	+20.0	-10.4	+10.8		
Washington					4/1	+20.0	-10.4	+10.8		
West Virginia									+48.8(c)	-5.3(d)
Wisconsin					2/1	+20.0	-10.4	+10.8		
Wyoming										
(a) ISO SUB-TOTAL								+ 6.4		
Hawaii					10/1	+20.0	-10.4	+10.8		
OTHER BUREAU SUB-TOTAL								+10.8		
(a) ALL STATES TOTAL								+ 6.4		

(a) Excludes Illinois.
(b) Staff Developed Rates. Date is manual edition date.
(c) Original Filing Amended.
(d) Scheduled for Implementation or Approved Effective First Quarter 1983.

PRODUCT LIABILITY

1983 RATE LEVEL REVISIONS   THROUGH FOURTH QUARTER

	STATE	INCREASED LIMITS EFF. DATE	INCREASED LIMITS B.I.	INCREASED LIMITS P.D.	BASIC RATE LEVEL CHANGE EFF. DATE	BASIC RATE LEVEL CHANGE B.I.	BASIC RATE LEVEL CHANGE P.D.	COMBINED TOTAL LIMITS	PENDING BASIC B.I.	PENDING BASIC P.D.
	Alabama									
	Alaska	8/1	0.0%	-20.2%				- 7.2%		
	Arizona	8/1	0.0	-20.2				- 7.2		
	Arkansas	8/1	0.0	-20.2				- 7.2		
(b)	California	8-83	0.0	-20.2				- 7.2		
(c)	Colorado	8-83	0.0	-20.2				- 7.2		
	Connecticut	8/1	0.0	-20.2				- 7.2		
	Delaware	9/1	0.0	-20.2				- 7.2		
	Dist. of Col.	9/1	0.0	-20.2				- 7.2	+20.0%	-10.4%(e)
	Florida	9/1	0.0	-20.2				- 7.2		
	Georgia	8/1	0.0	-20.2				- 7.2		
(b)	Idaho	8-83	0.0	-20.2				- 7.2		
	Illinois									
	Indiana	8/1	0.0	-20.2				- 7.2		
	Iowa	8/1	0.0	-20.2				- 7.2		
	Kansas	12/1	0.0	-20.2				- 7.2		
(b)	Kentucky	8-83	0.0	-20.2				- 7.2		
	Louisiana									
	Maine									
	Maryland	8/1	0.0	-20.2				- 7.2		
	Massachusetts	8/1	0.0	-20.2				- 7.2		
	Michigan	8/1	0.0	-20.2				- 7.2		
	Minnesota	8/1	0.0	-20.2				- 7.2		
	Mississippi	9/1	0.0	-20.2				- 7.2		
	Missouri	8/1	0.0	-20.2				- 7.2		
	Montana	8/1	0.0	-20.2				- 7.2		
	Nebraska	8/1	0.0	-20.2				- 7.2		
	Nevada	9/1	0.0	-20.2				- 7.2		
	New Hampshire	12/1	+10.1	+25.0(f)				+15.4		
	New Jersey									
	New Mexico	8/1	0.0	-20.2				- 7.2		
	New York									
	North Carolina								+62.4	- 5.3
	North Dakota	8/1	0.0	-20.2				- 7.2		
	Ohio	8/1	0.0	-20.2				- 7.2		
	Oklahoma									
	Oregon	8/1	0.0	-20.2				- 7.2		
	Pennsylvania	10/1	0.0	-20.2				- 7.2		
	Puerto Rico				3/1	+20.0%	-10.4%	+10.8		
	Rhode Island									
	South Carolina									
	South Dakota	8/1	0.0	-20.2				- 7.2		
	Tennessee	11/1	0.0	-20.2				- 7.2		
	Texas	12/1	0.0	-20.2				- 7.2		
	Utah	8/1	0.0	-20.2				- 7.2		
	Vermont	10/1	0.0	-20.2				- 7.2		
(d)	Virginia	8/1	0.0	-20.2				- 7.2		
	Washington	8/1	0.0	-20.2				- 7.2		
	West Virginia	3/1,10/1	-19.5	-20.2	3/1	+48.8	-5.3	+ 3.0(g)		
	Wisconsin	8/1	0.0	-20.2				- 7.2		
	Wyoming									
(a)	ISO SUB-TOTAL							- 3.9%		
	Hawaii									
	OTHER BUREAU SUB-TOTAL							0.0		
(a)	ALL STATES TOTAL							- 3.9%		

(a) Excludes Illinois.
(b) Date is manual edition date.
(c) Staff Developed Rates. Date is manual edition date.
(d) Staff Developed Rates.
(e) Withdrawn.
(f) Original Filing Amended.
(g) Combined Effect of Two Filings Effective in 1983.

PRODUCT LIABILITY

1984 RATE LEVEL REVISIONS THROUGH FOURTH QUARTER

	STATE	INCREASED LIMITS EFF. DATE	INCREASED LIMITS B.I.	INCREASED LIMITS P.D.	BASIC RATE LEVEL CHANGE EFF. DATE	BASIC RATE LEVEL CHANGE B.I.	BASIC RATE LEVEL CHANGE P.D.	COMBINED TOTAL LIMITS	PENDING BASIC B.I.	PENDING BASIC P.D.
	Alabama	7/1		- 8.2%	7/1	+ 5.0%	+35.0%	+10.6%		
	Alaska	4/1		-15.0	4/1	+ 5.0	+35.0	+ 7.8	+20.0%	+20.0%(e)
	Arizona	4/1		-15.0	4/1	+ 5.0	+35.0	+ 7.8	+20.0	+20.0(e)
	Arkansas	4/1		-15.0	4/1	+ 5.0	+35.0	+ 7.8	+20.0	+20.0(e)
(b)	California	4-84		-15.0	4-84	+ 5.0	+35.0	+ 7.8	+20.0	+20.0(e)
(c)	Colorado	4-84		-15.0	4-84	+ 5.0	+35.0	+ 7.8	+20.0	+20.0(e)
	Connecticut	4/1		-15.0	4/1	+ 5.0	+35.0	+ 7.8	+20.0	+20.0(e)
	Delaware	6/1		-15.0	6/1	+10.4	+14.7	+ 6.7		
	Dist. of Col.	6/1		-15.0	6/1	+26.0	+21.0	+19.3		
	Florida	4/1		-15.0	4/1	+ 5.0	+35.0	+ 7.8	+20.0	+20.0
	Georgia	4/1		-15.0	4/1	+ 5.0	+35.0	+ 7.8	+20.0	+20.0(e)
(b)	Idaho	4-84		-15.0	4-84	+ 5.0	+35.0	+ 7.8	+20.0	+20.0(e)
(f)	Illinois									
	Indiana	4/1		-15.0	4/1	+ 5.0	+35.0	+ 7.8	+20.0	+20.0(e)
	Iowa	4/1		-15.0	4/1	+ 5.0	+35.0	+ 7.8	+20.0	+20.0(e)
	Kansas	9/1		-15.0	9/1	+ 5.0	+35.0	+ 7.8	+20.0	+20.0
(f)	Kentucky	4/84		-15.0						
	Louisiana	10/1	-16.2	-28.0	10/1	+42.8(g)	+27.8	+12.1		
	Maine	2/1	0.0	+17.7	9/1	+ 5.0	+35.0	+20.4		
	Maryland	4/1		-15.0	4/1	+ 5.0	+35.0	+ 7.8	+20.0	+20.0(e)
	Massachusetts				10/1	+13.4	+ 8.8	+12.1		
	Michigan	4/1		-15.0	4/1	+ 5.0	+35.0	+ 7.8	+20.0	+20.0(e)
	Minnesota	4/1		-15.0	4/1	+ 5.0	+35.0	+ 7.8	+20.0	+20.0(e)
	Mississippi	8/1		-15.0	8/1	+ 5.0	+35.0	+ 7.8		
	Missouri	4/1		-15.0	4/1	+ 5.0	+35.0	+ 7.8	+20.0	+20.0(e)
	Montana	4/1		-15.0	4/1	+ 5.0	+35.0	+ 7.8	+20.0	+20.0(e)
	Nebraska								+26.0	+62.0(g)
	Nevada	5/1		-15.0	5/1	+ 5.0	+35.0	+ 7.8	+20.0	+20.0(e)
	New Hampshire				8/1	+12.7	+35.0	+18.8		
	New Jersey	5/1	+50.0	-28.0	5/1	0.0	+27.8	+33.2		
	New Mexico	4/1		-15.0	4/1	+ 5.0	+35.0	+ 7.8	+20.0	+20.0(e)
(c)	New York	6-84	-16.2	-28.0	6-84	+41.8	+20.0	+ 5.6		
	North Carolina	6/1	-16.2	0.0	6/1	+40.0	+27.8	+20.3		
	North Dakota	4/1		-15.0	4/1	+ 5.0	+35.0	+ 7.8	+20.0	+20.0(e)
	Ohio	4/1		-15.0	4/1	+ 5.0	+35.0	+ 7.8	+20.0	+20.0(e)
	Oklahoma									
	Oregon	4/1		-15.0	4/1	+ 5.0	+35.0	+ 7.8	+20.0	+20.0(e)
	Pennsylvania	7/1		-15.0	7/1	+ 5.0	+35.0	+ 7.8		
	Puerto Rico	11/1	0.0	-17.5	11/1	+ 5.0	+35.0	+ 6.9		
	Rhode Island	12/1	-16.2	-17.5	12/1	+35.0	+10.0	+ 7.0(h)		
	South Carolina								+26.0	+35.0
	South Dakota	4/1		-15.0	4/1	+ 5.0	+35.0	+ 7.8	+20.0	+20.0(e)
(c)	Tennessee	4-84		-15.0	4-84	+ 5.0	+35.0	+ 7.8	+20.0	+20.0(e)
	Texas	7/1		-15.0	7/1	+ 5.0	+35.0	+ 7.8		
	Utah	4/1		-15.0	4/1	+ 5.0	+35.0	+ 7.8	+20.0	+20.0(e)
	Vermont	8/1		-15.0	8/1	+ 5.0	+35.0	+ 7.8		
(d)	Virginia	4/1		-15.0	4/1	+ 5.0	+35.0	+ 7.8	+20.0	+20.0(e)
	Washington	4/1		-15.0	4/1	+ 5.0	+35.0	+ 7.8	+20.0	+20.0(e)
	West Virginia	4/1		-15.0	4/1	+14.7	+35.0	+14.7	+20.0	+20.0
	Wisconsin	4/1		-15.0	4/1	+ 5.0	+35.0	+ 7.8	+20.0	+20.0(e)
(c)	Wyoming	4-84		- 8.2	4-84	+13.4	+ 8.8	+ 9.5		
(a)	ISO SUB-TOTAL							+ 9.1		
	Hawaii									
	OTHER BUREAU SUB-TOTAL							0.0		
(a)	ALL STATES TOTAL							+ 9.1		

(a) Excludes Illinois.
(b) Date is manual edition date.
(c) Staff Developed Rates. Date is manual edition date.
(d) Staff Developed Rates.
(e) Scheduled for Implementation or Approved Effective First Quarter 1985.
(f) Staff Developed Loss Costs. Date is circular release.
(g) Previous Filing Withdrawn.
(h) Original Filing Amended.

PRODUCT LIABILITY

1985 RATE LEVEL REVISIONS THROUGH FOURTH QUARTER

	STATE	INCREASED LIMITS EFF. DATE	INCREASED LIMITS B.I.	INCREASED LIMITS P.D.	BASIC RATE LEVEL CHANGE EFF. DATE	BASIC RATE LEVEL CHANGE B.I.	BASIC RATE LEVEL CHANGE P.D.	COMBINED TOTAL LIMITS	PENDING BASIC B.I.	PENDING BASIC P.D.
	Alabama				9/1	+20.0%	+20.0%	+20.0%		
	Alaska				2/1	+20.0	+20.0	+20.0	+25.0%	+60.0%(b)
	Arizona				2/1	+20.0	+20.0	+20.0	+25.0	+60.0(b)
	Arkansas				2/1	+20.0	+20.0	+20.0	+25.0	+60.0(b)
(a)	California				2-85	+20.0	+20.0	+20.0	+25.0	+60.0(b)
(a)	Colorado				2-85	+20.0	+20.0	+20.0	+25.0	+60.0(b)
	Connecticut				3/1	+20.0	+20.0	+20.0		
	Delaware				12/1	+10.0(c)	+20.0	+13.4		
	Dist. of Col.				6/1	+20.0	+20.0	+20.0		
	Florida				4/1	+20.0	+20.0	+20.0	+25.0	+60.0
	Georgia				2/1	+20.0	+20.0	+20.0	+25.0	+60.0(b)
(a)	Idaho				2-85	+20.0	+20.0	+20.0	+25.0	+60.0(b)
	Illinois									
	Indiana				2/1	+20.0	+20.0	+20.0	+25.0	+60.0(b)
	Iowa				2/1	+20.0	+20.0	+20.0	+25.0	+60.0
	Kansas				9/1	+20.0	+20.0	+20.0		
	Kentucky									
	Louisiana				12/1	+25.0(c)	+25.0(c)	+25.0		
	Maine				11/1	+10.0(c)	+20.0	+13.4		
	Maryland				2/1	+20.0	+20.0	+20.0	+25.0	+60.0(L)
	Massachusetts									
	Michigan				2/1	+20.0	+20.0	+20.0	+25.0	+60.0(b)
	Minnesota				2/1	+20.0	+20.0	+20.0	+25.0	+60.0(b)
	Mississippi				8/1	+20.0	+20.0	+20.0		
	Missouri				2/1	+20.0	+20.0	+20.0	+25.0	+60.0(b)
	Montana				2/1	+20.0	+20.0	+20.0	+25.0	+60.0(b)
	Nebraska				3/1	+26.0	+62.0	+36.3	+25.0	+60.0
	Nevada				3/1	+20.0	+20.0	+20.0	+25.0	+60.0
	New Hampshire				9/1	+34.4	+20.0	+29.5		
	New Jersey				5/1	+46.3	+20.0	+37.3	+25.0	+60.0(b)
	New Mexico				2/1	+20.0	+20.0	+20.0	+25.0	+60.0(b)
(a)	New York				6-85	+24.1	+27.8	+25.4		
	North Carolina				6/1	+46.2	+20.0	+37.3		
	North Dakota				2/1	+20.0	+20.0	+20.0	+25.0	+60.0
	Ohio				2/1	+20.0	+20.0	+20.0	+25.0	+60.0(b)
	Oklahoma									
	Oregon				2/1	+20.0	+20.0	+20.0	+25.0	+60.0(b)
	Pennsylvania				6/1	+20.0	+20.0	+20.0		
	Puerto Rico								+20.0(b)	+20.0(b)
	Rhode Island									
	South Carolina									
	South Dakota				2/1	+20.0	+20.0	+20.0	+25.0	+60.0(b)
	Tennessee				4/1	+20.0	+20.0	+20.0		
	Texas				12/31	+20.0	+20.0	+20.0		
	Utah				2/1	+20.0	+20.0	+20.0	+25.0	+60.0(b)
	Vermont				8/1	+20.0	+20.0	+20.0		
	Virginia				2/1	+20.0	+20.0	+20.0	+25.0	+60.0(b)
	Washington				2/1	+20.0	+20.0	+20.0	+25.0	+60.0(b)
	West Virginia				4/1	+20.0	+20.0	+20.0	+25.0	+60.0
	Wisconsin				2/1	+20.0	+20.0	+20.0	+25.0	+60.0(b)
	Wyoming									
	ISO SUBTOTAL							+20.5		
	Hawaii									
	OTHER BUREAU SUBTOTAL							0.0		
	ALL STATES TOTAL							+20.3		

(a) Date is manual edition date.
(b) Scheduled for Implementation or Approved Effective First Quarter 1986.
(c) Original Filing Amended.

HOSPITAL PROFESSIONAL LIABILITY

1981 RATE LEVEL REVISIONS THROUGH FOURTH QUARTER

	INCREASED LIMITS		BASIC RATE LEVEL CHANGE			
STATE	EFF. DATE	B.I.	EFF. DATE	B.I.	COMBINED TOTAL LIMITS	PENDING BASIC B.I.
Alabama	7/1	+14.2%	7/1	-10.0%	+ 2.8%	
Alaska						
Arizona	4/1	+14.2			+ 14.2	+ 10.0%(a)
Arkansas	4/1	+14.2			+ 14.2	
California	4/1	+14.2			+ 14.2	
(d)Colorado	4/1	+14.2			+ 14.2	
Connecticut	8/1	+14.2	8/1	+20.0	+ 37.0	
Delaware						+ 15.0
Dist. of Col.	11/1	+16.8			+ 16.8	
Florida	4/1	+14.2	4/1	-10.0	+ 2.8	
Georgia	4/1	+14.2			+ 14.2	
Idaho	4/1	+14.2	4/1	+50.0	+ 71.3	
Illinois						
Indiana	4/1	+14.2			+ 14.2	+ 52.2(a)
Iowa						+ 37.4
Kansas						+ 42.6(b)(a)
Kentucky						
Louisiana	6/1	+63.0	6/1	-15.0	+ 38.6	
Maine			10/1	+20.0(b)	+ 20.0	
Maryland	4/1	+14.2			+ 14.2	
Massachusetts						
Michigan	4/1	+14.2			+ 14.2	+ 22.4
Minnesota	4/1	+14.2	4/1	+20.0	+ 37.0	+ 43.5(a)
Mississippi						+ 7.6
Missouri	4/1	+14.2	4/1	+15.0	+ 31.3	+ 50.0(a)
Montana	4/1	+14.2	4/1	-10.0	+ 2.8	
Nebraska			4/1	+20.0	+ 20.0	
Nevada	4/1	+14.2			+ 14.2	
New Hampshire			4/1	+50.0	+ 50.0	
New Jersey						
New Mexico	4/1	+14.2	4/1	+20.0	+ 37.0	
New York			6/1	+55.0(b)	+ 55.0	
North Carolina	4/1	+33.4			+ 33.4	
North Dakota	4/1	+16.8			+ 16.8	+100.0(a)
Ohio	4/1	+33.4			+ 33.4	
Oklahoma			6/1	+15.0	+ 15.0	
Oregon	4/1	+14.2			+ 14.2	
Pennsylvania	8/1	+33.4	8/1	+56.0(b)	+108.1	
Puerto Rico						
Rhode Island						
South Carolina	5/1	+14.2			+ 14.2	
South Dakota	7/1	+14.2			+ 14.2	+ 50.0(a)
Tennessee						
Texas						
Utah	4/1	+14.2	4/1	-15.0	- 2.9	
Vermont	8/1	+42.7(b)	8/1	-10.0	+ 28.4	
Virginia						
Washington	4/1	+14.2			+ 14.2	- 20.0(a)
West Virginia						
Wisconsin	4/1	+14.2	4/1	+20.0	+ 37.0	
Wyoming						
(c) ISO SUB-TOTAL					+ 20.5	
Hawaii					0.0	
OTHER BUREAU SUB-TOTAL					0.0	
(c) ALL STATES TOTAL					+ 20.4	

(a) Approved Effective First Quarter 1982.
(b) Original Filing Amended.
(c) Excludes Illinois.
(d) Staff Developed Rates. Date is manual edition date.

HOSPITAL PROFESSIONAL LIABILITY

1982 RATE LEVEL REVISIONS

THROUGH FOURTH QUARTER

STATE	INCREASED LIMITS EFF. DATE	INCREASED LIMITS B.I.	BASIC RATE LEVEL CHANGE EFF. DATE	BASIC RATE LEVEL CHANGE B.I.	COMBINED TOTAL LIMITS	PENDING BASIC B.I.
Alabama						+33.7%
Alaska						
Arizona			1/1	+10.0%	+10.0%	
Arkansas						
California						
Colorado						
Connecticut						
Delaware	7/1	+33.4%	7/1	+15.0	+53.4	
Dist. of Col.						
Florida			7/1	+27.5	+27.5	
Georgia						
Idaho						
Illinois						
Indiana			1/1	+52.2	+52.2	
Iowa	7/1	+14.2	3/1	+30.0(b)	+48.5	
Kansas			1/1	+42.6(b)	+42.6	
Kentucky						
Louisiana						
Maine						
Maryland						
Massachusetts						
Michigan			3/1	+22.4	+22.4	
Minnesota			1/1	+43.5	+43.5	
Mississippi	9/1	+13.7	6/1	+ 7.6	+22.3	
Missouri			1/1	+50.0	+50.0	
Montana						
Nebraska						
Nevada						
New Hampshire						
New Jersey						
New Mexico						
New York						
North Carolina						
North Dakota			3/1	+100.0	+100.0	
Ohio						
Oklahoma						
Oregon						
Pennsylvania						
Puerto Rico						
Rhode Island						
South Carolina						
South Dakota			2/1	+50.0	+50.0	
Tennessee	1/1	+42.8(b)			+42.8	
Texas						
Utah						
Vermont						
Virginia						
Washington			3/1	-20.0	-20.0	
West Virginia						
Wisconsin						
Wyoming						
(a) ISO SUB-TOTAL					+12.5	
Hawaii						
OTHER BUREAU SUB-TOTAL					0.0	
(a) ALL STATES TOTAL					+12.5	

(a) Excludes Illinois.
(b) Original Filing Amended.

HOSPITAL PROFESSIONAL LIABILITY

1983 RATE LEVEL REVISIONS | THROUGH FOURTH QUARTER

		INCREASED LIMITS		BASIC RATE LEVEL CHANGE		COMBINED TOTAL LIMITS	PENDING BASIC B.I.
	STATE	EFF. DATE	B.I.	EFF. DATE	B.I.		
	Alabama						
	Alaska						
	Arizona			5/1	-10.0%	-10.0%	
	Arkansas						
	California						
(d)	Colorado			5-83	+10.0	+10.0	
	Connecticut			9/1	+16.4	+16.4(b)	
	Delaware			9/1	+10.5	+10.5(b)	
	Dist. of Col.			9/1	+35.0	+35.0(b)	
	Florida						
	Georgia						
(e)	Idaho			5-83	+43.9	+43.9	
(c)	Illinois			3/21			
	Indiana			5/1	+15.0	+15.0	
	Iowa						+15.0%
	Kansas			12/1	+15.7	+15.7	
	Kentucky						
	Louisiana						
	Maine			7/1	+50.0	+50.0(b)	
	Maryland			8/1	+100.0	+100.0	
	Massachusetts						
	Michigan			5/1	+52.5	+52.5	
	Minnesota						
	Mississippi			10/1	+25.0	+25.0	
	Missouri						
	Montana			5/1	+26.8	+26.8	
	Nebraska						
	Nevada						
	New Hampshire						
	New Jersey						
	New Mexico						
	New York						
	North Carolina						
	North Dakota						
	Ohio						
	Oklahoma						
	Oregon			5/1	+25.0	+25.0	
	Pennsylvania						
	Puerto Rico						
	Rhode Island						
	South Carolina						
	South Dakota						
	Tennessee						
	Texas						
	Utah			5/1	+80.0	+80.0	
	Vermont						
(f)	Virginia	10/1	+ 9.2%(b)			+ 9.2	
	Washington			5/1	+27.9	+27.9	
	West Virginia						
	Wisconsin						
	Wyoming						
(a)	ISO SUB-TOTAL					+15.7%	
	Hawaii						
	OTHER BUREAU SUB-TOTAL					0.0	
(a)	ALL STATES TOTAL					+15.6%	

(a) Excludes Illinois.
(b) Original Filing Amended.
(c) Adjusted Loss Costs Information. Date is circular release.
(d) Staff Developed Rates. Date is manual edition date.
(e) Date is manual edition date.
(f) Staff Developed Rates.

HOSPITAL PROFESSIONAL LIABILITY

1984 RATE LEVEL REVISIONS THROUGH FOURTH QUARTER

		INCREASED LIMITS		BASIC RATE LEVEL CHANGE			
	STATE	EFF. DATE	B.I.	EFF. DATE	B.I.	COMBINED TOTAL LIMITS	PENDING BASIC B.I.
	Alabama			8/1	+ 17.0%(g)	+ 17.0%	
	Alaska	5/1	+40.1%			+ 40.1	
	Arizona			4/1	+ 35.0	+ 35.0	
	Arkansas			4/1	+ 35.0	+ 35.0	
(e)	California						
(d)	Colorado						
	Connecticut			5/1	+ 13.7	+ 13.7	+25.0%
	Delaware						
	Dist. of Col.			9/1	+ 35.0	+ 35.0	
	Florida			10/1	+ 66.0(g)	+ 66.0	
	Georgia						+27.1(f)
(e)	Idaho			4-84	+ 20.0	+ 20.0	+50.0(f)
(c)	Illinois			2/21			
	Indiana						+20.0(f)
	Iowa			5/1	+ 40.0	+ 40.0	+34.5(f)
	Kansas	9/1	+40.1			+ 40.1	
(c)	Kentucky	3/6	+46.5	3/6	+ 8.1	+ 58.4	
	Louisiana						
	Maine	8/1	+31.3	8/1	+ 30.0	+ 70.7	
	Maryland						
	Massachusetts						
	Michigan			4/1	+ 14.6	+ 14.6	
	Minnesota						
	Mississippi			11/1	+ 20.0(g)	+ 20.0	
	Missouri						
	Montana						
	Nebraska						
	Nevada						
	New Hampshire						
	New Jersey	5/1	+46.5			+ 46.5	
	New Mexico			4/1	+100.0	+100.0	
(d)	New York						
	North Carolina						
	North Dakota	7/1	+40.1	7/1	+ 35.0	+ 89.1	+50.0
	Ohio			4/1	+ 25.0	+ 25.0	
	Oklahoma						
	Oregon			4/1	+ 25.0	+ 25.0	
	Pennsylvania						
	Puerto Rico						
	Rhode Island						
	South Carolina			6/1	+154.6	+154.6	
	South Dakota						
(d)	Tennessee	5-84	+40.1			+ 40.1	
	Texas						
	Utah			4/1	+ 35.0	+ 35.0	+35.0(f)
	Vermont	9/1	+14.0	9/1	+ 12.1	+ 27.8	
(b)	Virginia						+25.0
	Washington			8/1	+ 18.4	+ 18.4	
	West Virginia	11/1	+58.6	11/1	+ 80.0(g)	+185.5	
	Wisconsin			4/1	+ 33.8	+ 33.8	
(d)	Wyoming	4-84	+40.1	4-84	+100.0	+180.2	
(a)	ISO SUB-TOTAL					+ 20.4	
	Hawaii						
	OTHER BUREAU SUB-TOTAL					0.0	
(a)	ALL STATES TOTAL					+ 20.4	

(a) Excludes Illinois.
(b) Staff Developed Rates.
(c) Staff Developed Loss Costs. Date is circular release.
(d) Staff Developed Rates. Date is manual edition date.
(e) Date is manual edition date.
(f) Scheduled for Implementation or Approved Effective First Quarter 1985.
(g) Original Filing Amended.

HOSPITAL PROFESSIONAL LIABILITY

1985 RATE LEVEL REVISIONS THROUGH FOURTH QUARTER

STATE	INCREASED LIMITS EFF. DATE	INCREASED LIMITS B.I.	BASIC RATE LEVEL CHANGE EFF. DATE	BASIC RATE LEVEL CHANGE B.I.	COMBINED TOTAL LIMITS	PENDING BASIC B.I.
Alabama			9/1	+46.3%(c)	+46.3%	
Alaska						
Arizona			7/1	+50.0	+ 50.0	
Arkansas						
(a) California						
(a) Colorado						
Connecticut			5/1	+ 25.0	+ 25.0	
Delaware			12/1	+ 25.0 (c)	+ 25.0	
Dist. of Col.	6/1	+ 40.1%	7/1	+ 20.0	+ 68.1	
Florida			8/1	+ 50.0	+ 50.0	
Georgia			3/1	+ 27.1	+ 27.1	
(a) Idaho			3-85	+ 50.0	+ 50.0	
(b) Illinois			1/23	+ 7.5	+ 7.5	
Indiana			3/1	+ 20.0	+ 20.0	
Iowa			3/1	+ 34.5	+ 34.5	
Kansas			9/1	+ 50.0	+ 50.0	
(b) Kentucky			2/11	+ 45.9	+ 45.9	
Louisiana			4/1	+ 25.0	+ 25.0	
Maine			7/1	+ 50.0(c)	+ 50.0	
Maryland			4/1	+ 50.0	+ 50.0	
Massachusetts						
Michigan			3/1	+ 24.3	+ 24.3	
Minnesota			3/1	+ 12.9	+ 12.9	
Mississippi			11/1	+ 20.0	+ 20.0	
Missouri			3/1	+ 50.0	+ 50.0	
Montana			3/1	+ 50.0	+ 50.0	
Nebraska			11/1	+ 9.9	+ 9.9	
Nevada						
New Hampshire	9/1	+29.3(c)			+29.3	
New Jersey			3/1	0.0	0.0	
New Mexico						
(a) New York						+ 50.0%
North Carolina			3/1	+ 21.4	+ 21.4	
North Dakota			3/1	+ 50.0	+ 50.0	
Ohio			3/1	+ 50.0	+ 50.0	
Oklahoma			9/1	+ 30.0	+ 30.0	
Oregon			3/1	+ 28.6	+ 28.6	
Pennsylvania						
Puerto Rico						
Rhode Island						
South Carolina						
South Dakota						
Tennessee			4/1	+ 40.0	+ 40.0	
Texas						
Utah			3/1	+ 35.0	+ 35.0	
Vermont			7/1	+ 20.0	+ 20.0	
Virginia			4/1	+ 25.0	+ 25.0	
Washington			4/1	+ 50.0	+ 50.0	
West Virginia						+100.0
Wisconsin			3/1	+ 24.0	+ 24.0	
(b) Wyoming			5/1	+ 75.0	+ 75.0	
ISO SUB-TOTAL					+ 26.6	
Hawaii						
OTHER BUREAU SUB-TOTAL					0.0	
ALL STATES TOTAL					+ 26.4	

(a) Date is manual edition date.
(b) Loss Costs. Date is circular release.
(c) Original Filing Amended.

PHYSICIANS, SURGEONS AND DENTISTS PROFESSIONAL LIABILITY

1981 RATE LEVEL REVISIONS THROUGH FOURTH QUARTER

	INCREASED LIMITS		BASIC RATE LEVEL CHANGE		COMBINED TOTAL LIMITS	PENDING BASIC B.I.
STATE	EFF. DATE	B.I.	EFF. DATE	B.I.		
Alabama						
Alaska						
Arizona	2/1	+ 5.5%	2/1	- 10.0%	- 5.0%	
Arkansas	2/1	+ 5.5	2/1	- 10.0	- 5.0	
California	2/1	+ 5.5	2/1,12/1	- 36.2(i)	- 32.7	
(e) Colorado	2/1	+ 5.5	2/1	- 15.0	- 10.3	
Connecticut	2/1	+ 5.5			+ 5.5	+26.6 %
Delaware						
Dist. of Col.	7/1	+30.6	7/1	+ 30.0	+ 69.8	
Florida	2/1	+ 5.5	2/1	- 10.0	- 5.0	
Georgia	2/1	+ 5.5	2/1	+ 14.7	+ 21.0	+22.4(d)
Idaho	2/1	+ 5.5	12/1	+ 15.0	+ 21.3	
Illinois						
Indiana	2/1	+ 5.5	12/1	+ 15.3	+ 21.6	
Iowa	2/1	+ 5.5			+ 5.5	+ 50.0(d)
Kansas						+ 26.0(d)
Kentucky						+ 20.0
Louisiana						+135.8
Maine			4/1	+ 25.0(c)	+ 25.0	+ 96.2
Maryland						+ 53.0
Massachusetts						
Michigan	2/1	+ 5.5	12/1	- 15.0	- 10.3	
Minnesota	2/1	+ 5.5	2/1,12/1	+ 59.4(i)	+ 68.1	
Mississippi			3/1	+ 25.0	+ 25.0	+ 25.0(d)
Missouri	2/1	+ 5.5	2/1,12/1	+ 46.1(i)	+ 54.1	
Montana	2/1	+ 5.5	2/1,12/1	- 12.5(i)	+ 18.7	
Nebraska	3/1	+30.6	3/1	- 10.0	+ 17.5	+ 15.0(d)
Nevada	3/1	+ 5.5	3/1,12/1	+ 8.0(i)	+ 13.9	
New Hampshire			4/1	+117.5	+117.5	+ 50.0(d)
New Jersey						+ 31.7(b)(c)(f)
New Mexico	2/1	+ 5.5			+ 5.5	
New York						
North Carolina	2/1	+30.6	2/1	+ 50.0	+ 95.9	
North Dakota	4/1	+ 5.5	4/1	+ 12.0(c)	+ 18.2	
Ohio	3/1	+30.6	12/1	+ 33.0	+ 73.7	
Oklahoma			10/1	+ 4.8(c)	+ 4.8	
Oregon	2/1	+ 5.5	2/1,12/1	- 36.0(i)	- 32.5	
Pennsylvania			2/1	+ 82.8(c)	+ 82.8	
Puerto Rico						+125.0
Rhode Island						+ 12.7(d)
South Carolina	5/1	+30.6			+ 30.6	
South Dakota	2/1	+ 5.5	2/1	- 15.0	- 10.3	+ 15.0(c)(d)
Tennessee						+ 40.0(h)
Texas						
Utah	2/1	+ 5.5	2/1,12/1	+ 20.0(i)	+ 26.6	
Vermont	2/1	+30.6	2/1	- 23.4(c)	0.0	+ 23.4
Virginia						+ 25.0(g)
Washington	3/1	+ 5.5	3/1	+ 22.6	+ 29.3	+ 30.5(d)
West Virginia						+ 22.4
Wisconsin	2/1	+ 5.5	2/1,12/1	- 6.5(i)	- 1.4	
Wyoming						
(a) ISO SUB-TOTAL					+ 20.3	
Hawaii					0.0	
OTHER BUREAU SUB-TOTAL					0.0	
(a) ALL STATES TOTAL					+ 20.2	

(a) Excludes Illinois.
(b) Physicians and Surgeons Classifications Only: +24.6%.
(c) Original Filing Amended.
(d) Approved Effective First Quarter 1982.
(e) Staff Developed Rates. Date is manual edition date.
(f) Dentists Classifications Only: + 70.4%.
(g) Reference Document Suspended.
(h) Disapproved.
(i) Combined Effect of Two Filings Effective in 1981.

PHYSICIANS, SURGEONS AND DENTISTS PROFESSIONAL LIABILITY

1982 RATE LEVEL REVISIONS THROUGH FOURTH QUARTER

	INCREASED LIMITS		BASIC RATE LEVEL CHANGE			
STATE	EFF. DATE	B.I.	EFF. DATE	B.I.	COMBINED TOTAL LIMITS	PENDING BASIC B.I.
Alabama			4/1	+97.3%(b)	+97.3%	
Alaska						
Arizona						
Arkansas						
California						
Colorado						
Connecticut			4/1	+15.0(c)	+15.0	
Delaware	2/1	+23.3%(c)			+23.3	+100.0%
Dist. of Col.						
Florida						
Georgia			2/1	+22.4	+22.4	
Idaho						
Illinois						
Indiana						
Iowa			2/1	+50.0	+50.0	
Kansas			1/1	+26.0	+26.0	
Kentucky						
Louisiana	7/1	+58.4			+58.4	
Maine			6/1	+35.0(c)	+35.0	
Maryland						+110.3
Massachusetts						
Michigan						
Minnesota						+16.7(e)
Mississippi	5/1	+13.3(c)	3/1	+25.0	+41.6	
Missouri						
Montana						
Nebraska			1/1	+15.0	+15.0	
Nevada						
New Hampshire			1/1	+50.0	+50.0	
New Jersey			8/1,12/1	+34.1(d)	+34.1	
New Mexico						
New York						
North Carolina						+25.0
North Dakota						
Ohio						
Oklahoma						
Oregon						
Pennsylvania						
Puerto Rico	8/1	+30.6	8/1	+63.3(c)	+113.3	
Rhode Island			1/1,12/1	+37.7(d)	+37.7	
South Carolina						
South Dakota			1/1	+15.0(c)	+15.0	
Tennessee						
Texas						
Utah						
Vermont			3/1	+23.4	+23.4	
Virginia						+25.0
Washington			3/1	+30.5	+30.5	
West Virginia	2/1	+30.6			+30.6	
Wisconsin						
Wyoming						
(a) ISO SUB-TOTAL					+15.0	
Hawaii						
OTHER BUREAU SUB-TOTAL					0.0	
(a) ALL STATES TOTAL					+14.8	

(a) Excludes Illinois.
(b) Physicians and Surgeons Classifications Only: +100.0%.
(c) Original Filing Amended.
(d) Combined Effect of Two Filings Effective in 1982.
(e) Scheduled for Implementation or Approved Effective First Quarter 1983.

PHYSICIANS, SURGEONS AND DENTISTS PROFESSIONAL LIABILITY

1983 RATE LEVEL REVISIONS THROUGH FOURTH QUARTER

	STATE	INCREASED LIMITS EFF. DATE	INCREASED LIMITS B.I.	BASIC RATE LEVEL CHANGE EFF. DATE	BASIC RATE LEVEL CHANGE B.I.	COMBINED TOTAL LIMITS	PENDING BASIC B.I.
	Alabama						
	Alaska			5/1	+100.0%	+100.0%	
	Arizona						
	Arkansas						
	California						
(g)	Colorado			6-83	+13.7	+13.7	
	Connecticut			9/1	+25.0	+25.0(c)	
	Delaware			5/1	+129.3	+129.3(c)	
	Dist. of Col.			6/1	+11.8	+11.8	
	Florida						
	Georgia						
(h)	Idaho			3-83	+50.0	+50.0	
(d)	Illinois			3/7			
	Indiana						
	Iowa			5/1	+20.0	+20.0	
	Kansas						
	Kentucky						
	Louisiana						
	Maine			7/1	+35.0	+35.0(c)	
	Maryland			6/1	+110.3	+110.3	
	Massachusetts						
	Michigan			5/1	+50.0	+50.0	
	Minnesota			4/1	+16.7	+16.7	
	Mississippi			6/1	+25.0	+25.0	
	Missouri			4/1	+39.2	+39.2	
	Montana			4/1	+80.3	+80.3	
	Nebraska						
	Nevada			5/1	+50.0	+50.0	
	New Hampshire	9/15	+23.3%	5/1, 9/15	+121.3(f)	+172.9	
	New Jersey						
	New Mexico			4/1	+20.0	+20.0	
	New York						+138.3%(b)(e)
	North Carolina			7/1	+30.0	+30.0	
	North Dakota			4/1	+36.2	+36.2	
	Ohio			4/1	+17.9	+17.9	
	Oklahoma						+ 53.9
	Oregon						
	Pennsylvania	1/1	+30.6	1/1	- 4.7	+24.5	
	Puerto Rico						
	Rhode Island						+ 24.0(b)(e)
	South Carolina			10/1	+ 7.5	+ 7.5(c)	
	South Dakota			5/1	+50.0	+50.0	
	Tennessee						
	Texas						
	Utah			4/1	+100.0	+100.0	
	Vermont			11/1	+30.0	+30.0(c)	
(i)	Virginia	10/1	+10.2	10/1	+23.4	+ 36.0(c)	
	Washington			7/1	+23.8	+ 23.8	
	West Virginia						+200.0(c)
	Wisconsin			4/1	+14.0	+14.0	
	Wyoming						
(a)	ISO SUB-TOTAL					+18.6%	
	Hawaii			11/1	+ 3.8(j)	+ 3.8	
	OTHER BUREAU SUB-TOTAL					0.0%	
(a)	ALL STATES TOTAL					+18.5%	

(a) Excludes Illinois.
(b) Scheduled for Implementation or Approved Effective First Quarter 1984.
(c) Original Filing Amended.
(d) Adjusted Loss Costs Information. Date is circular release.
(e) Physicians and Surgeons Only.
(f) Combined Effect of Two Filings Effective in 1983.
(g) Staff Developed Rates. Date is manual edition date.
(h) Date is manual edition date.
(i) Staff Developed Rates.
(j) Dentists only.

PHYSICIANS, SURGEONS AND DENTISTS PROFESSIONAL LIABILITY

1984 RATE LEVEL REVISIONS THROUGH FOURTH QUARTER

		INCREASED LIMITS		BASIC RATE LEVEL CHANGE			
	STATE	EFF. DATE	B.I.	EFF. DATE	B.I.	COMBINED TOTAL LIMITS	PENDING BASIC B.I.
	Alabama	10/1	+18.2%	10/1	+ 50.0%	+ 77.3%	
	Alaska	4/1	+14.4	4/1	+100.0	+128.8	
	Arizona			5/1	+ 20.0	+ 20.0	+ 25.0(h)
	Arkansas						+ 18.2(h)
(d)	California						+ 25.0(h)
(c)	Colorado						+ 24.0(h)
	Connecticut			6/1	+ 38.0	+ 38.0	
	Delaware						+ 57.5
	Dist. of Col.			7/1	+ 21.5(g)	+ 21.5	+ 59.2
	Florida			9/1	+100.0	+100.0	
	Georgia						+ 12.9(h)
(d)	Idaho			4-84	+ 15.0	+ 15.0	+ 45.5(h)
(b)	Illinois			2/21			
	Indiana						+ 36.1(h)
	Iowa			5/1	+ 31.4	+ 31.4	+ 35.0(h)
	Kansas						+ 58.3
(b)	Kentucky	3/6	+18.2	3/6,11/27	+226.5(i)	+286.0	
	Louisiana						
	Maine	7/1	+ 9.3			+ 9.3	+ 12.1
	Maryland	6/1	+18.2	6/1	+ 35.0	+ 59.6	
	Massachusetts						
	Michigan			4/1	- 24.2	- 24.2	+100.0(h)
	Minnesota						+ 6.9(h)
	Mississippi			8/1	+ 25.0	+ 25.0	
	Missouri			4/1	+ 20.1	+ 20.1	+ 50.0(h)
	Montana			4/1	+ 21.9	+ 21.9	+ 8.8(h)
	Nebraska			5/1	+ 21.9	+ 21.9	
	Nevada						
	New Hampshire						
	New Jersey	5/1	+18.8	5/1	+100.0	+137.6	
	New Mexico			4/1	+100.0	+100.0	+ 25.0(h)
(c)	New York			2/1	+138.3(f)	+138.3	
	North Carolina			7/1	+ 40.4	+ 40.4	
	North Dakota			4/1	+ 39.9	+ 39.9	+ 50.0
	Ohio			4/1	+ 35.0	+ 35.0	+ 21.3(h)
	Oklahoma			11/1	+ 20.0	+ 20.0	
	Oregon			4/1	+100.0	+100.0	+ 26.9(h)
	Pennsylvania			6/1	+ 13.8(f)	+ 13.8	
	Puerto Rico						+100.0
	Rhode Island	11/1	+13.0	1/1,11/1	+ 38.3(i)	+ 56.2	
	South Carolina						+ 37.4
	South Dakota			4/1	+ 10.0	+ 10.0	
(c)	Tennessee	8/1	+23.3	8/1	+100.0	+146.6	
	Texas						
	Utah			4/1	+ 50.0	+ 50.0	
	Vermont						
(e)	Virginia						+ 50.0
	Washington			12/1	+ 57.1	+ 57.1	
	West Virginia			3/1	+ 99.1(g)	+ 99.1	+100.0
	Wisconsin			4/1	+ 60.1	+ 60.1	+ 19.3(h)
(c)	Wyoming	4-84	+14.4	4-84	+ 75.0	+100.2	
(a)	ISO SUB-TOTAL					+ 47.3	
	Hawaii						
	OTHER BUREAU SUB-TOTAL					0.0	
(a)	ALL STATES TOTAL					+ 47.0	

(a) Excludes Illinois.
(b) Staff Developed Loss Costs. Date is circular release.
(c) Staff Developed Rates. Date is manual edition date.
(d) Date is manual edition date.
(e) Staff Developed Rates.
(f) Physicians and Surgeons Only.
(g) Original Filing Amended.
(h) Scheduled for Implementation or Approved Effective First Quarter 1985.
(i) Combined Effect of Two Filings Effective in 1984.

INSURANCE SERVICES OFFICE, INC.

Exhibit 12

PHYSICIANS, SURGEONS AND DENTISTS PROFESSIONAL LIABILITY

1985 RATE LEVEL REVISIONS

THROUGH FOURTH QUARTER

STATE	INCREASED LIMITS		BASIC RATE LEVEL CHANGE		COMBINED TOTAL LIMITS	PENDING	
	EFF. DATE	B.I.	EFF. DATE	B.I.		BASIC LIMITS B.I.	INCREASED LIMITS B.I.
Alabama							
Alaska	3/1	+ 5.6%			+ 5.6%		
Arizona	7/1	+ 5.6	7/1	+-25.0%	+ 32.0		
Arkansas	1/1	+ 5.6	1/1	+ 18.2	+ 24.8	+23.9%	
(a) California	1-85	+ 5.6	1-85	+ 25.0	+ 32.0		
(a) Colorado	1-85	+ 5.6	1-85	+ 24.0	+ 30.9		
Connecticut	3/1	+ 5.6			+ 5.6		
Delaware	12/1	+ 7.0(c)	12/1	+ 10.3(c)	+ 18.0		
Dist. of Col.	7/1	+ 5.6	7/1	+ 37.3(c)	+ 45.0		
Florida	1/1	+ 5.6			+ 5.6		
Georgia	1/1	+ 5.6	1/1	+ 12.9	+ 19.2		
(a) Idaho	3-85	+ 5.6	3-85	+ 45.5	+ 53.6		
(b) Illinois	8-85(a)	+ 5.6	1/23	+ 45.6	+ 45.6		
Indiana	1/1	+ 5.6	1/1	+ 36.1	+ 43.7		
Iowa	3/1	+ 5.6	3/1	+ 35.0	+ 42.6		
Kansas	10/1	+31.9	10/1	+ 58.3	+108.8		
(b) Kentucky	3-85(a)	+ 5.6			+ 5.6		
(b) Louisiana			1/18	+324.8	+324.8		
Maine	5/1	+ 5.3	5/1	+ 5.0	+ 10.6		
Maryland	3/1	+ 5.6			+ 5.6		
Massachusetts							
Michigan	1/1	+ 5.6	1/1	+100.0	+111.2		
Minnesota	1/1	+ 5.6	1/1	+ 6.9	+ 12.9		
Mississippi							
Missouri	3/1	+ 5.6	3/1	+ 50.0	+ 58.4		
Montana	1/1	+ 5.6	1/1	+ 8.8	+ 14.9		
Nebraska							+ 5.6%
Nevada	2/1	+ 5.6			+ 5.6		
New Hampshire			3/1	+ 5.1	+ 5.1		
New Jersey	6/1	+ 5.6	6/1	+ 75.0	+ 84.8		
New Mexico	1/1	+ 5.6	1/1	+ 25.0	+ 32.0		
(a) New York			(d)	+138.9	+138.9		
North Carolina	1/1	+ 5.6			+ 5.6		
North Dakota	3/1	+ 5.6	3/1	+ 50.0	+ 58.4		
Ohio	3/1	+ 5.6	3/1	+ 21.3	+ 28.1		
Oklahoma							
Oregon	3/1	+ 5.6	3/1	+ 26.9	+ 34.0		
Pennsylvania			8/1	+ 30.6(c)	+ 30.6		
Puerto Rico	6/30	+ 5.6	6/30	+ 75.3(c)	+ 85.1		
Rhode Island							
South Carolina	7/1	+ 5.6	7/1	+18.4(c)	+ 25.0		
South Dakota	3/1	+ 5.6			+ 5.6		
Tennessee	2/1	+ 5.6			+ 5.6		
Texas							
Utah	1/1	+ 5.6			+ 5.6		
Vermont	1/1	+ 5.6			+ 5.6		
Virginia						+ 50.0	+19.1
Washington	3/1	+ 5.6			+ 5.6		
West Virginia						+100.0	+ 5.6
Wisconsin	3/1	+ 5.6	3/1	+ 19.3	+ 26.0		
(b) Wyoming	2/14	+ 5.6	2/13	+119.5	+131.8		
ISO SUB-TOTAL					+ 46.6		
Hawaii	7/1	+31.9	7/1	+60.0	+111.0		
OTHER BUREAU SUB-TOTAL					+111.0		
ALL STATES TOTAL					+ 47.1		

(a) Date is manual edition date.
(b) Loss Costs. Date is circular release.
(c) Original Filing Amended
(d) Physicians and Surgeons +82.5% effective 7-85; Dentists +209.8% effective 12-85.

ITEM #4:

YEAR-END 1985 OPERATING RESULTS

BEST'S INSURANCE MANAGEMENT REPORTS

Property/Casualty
Release No. 9
April 7, 1986

A.M. Best Company
Oldwick, N.J. 08858
201-439-2200

Financial News | Washington Review | Perspectives | On-Line Reports

1985 Property/Casualty Results: An Updated Review and Preview

Considering the volatility and surprises of the property/casualty insurance industry of late, most industry participants and watchers may be steeled to accept almost any startling development. Fortunately, this update of A.M. Best Company's estimates of year-end 1985 property/casualty results—first published in our "Review and Preview" dated December 30, 1985—shows only relatively minor variances from our first projections. And most of these adjustments are on the positive side, despite major tenth-inning increases of reserves.

In a nutshell, compilations based on actual results show a lesser underwriting loss than seen earlier, but still one of $24.6 billion, which is significantly larger than 1984's.

As shown in our table of property/casualty industry operating results on the last page, the estimated 1985 pre-tax operating loss was $4.96 billion. Although our primary interest is measurement of industry performance which best is shown by operating income, we see a net income of about $2 billion for the industry after considering $5 billion in capital gains realized and a net of $2 billion in federal tax refunds. There can be little consolation in this, as it amounts to but 1.5% of premiums earned (or 2.6% of year-end net worth), and the capital gains realized were fortuitous. A $5 billion operating loss in a year of falling securities prices would have been disastrous.

Surplus Is Up 21%

Underwriting and operating losses notwithstanding, investment income, capital gains, tax refunds and new capital contributed to a $13 billion growth of policyholders' surplus. Based upon our estimates of $144 billion premiums written in 1985 and a December 31, 1985 policyholders' surplus of $76.5 billion, the year-end premiums-to-surplus ratio was 1.88-to-1.

1985 Estimated Changes in Policyholders' Surplus

	($ millions)
Policyholders' Surplus 1/1/85	63,398
Underwriting Profit/Loss*	−24,560
Net Investment Income**	19,720
Capital Gains	10,000
All Other Changes***	7,942
Policyholders' Surplus 12/31/85	76,500

*After policyholders' dividends and before federal taxes.
**Before federal taxes.
***Including federal income taxes.

Among the "other changes" category in this table are federal tax refunds, dividends to stockholders, other income, miscellaneous changes and $8 billion of new capital raised in 1985. Last year the industry had little problem in raising new funds from capital markets. Insurance stocks have been in such favor with investors that property/casualty stocks on the Best's Insurance Stock Index appreciated 50% during 1985—and almost another 22% in the first quarter of 1986. In the same 15 months this insurance stock index was growing by 83%, the S&P 500 gained only 43% in value. Securities analysts have been saying that insurance stocks are being bought for anticipated 1987 profits. Despite continued strength of insurance stocks in the past few weeks, analysts formerly bullish on property/casualty issues lately are backing off and are becoming—to use their euphemism—"more selective."

To many who follow the underwriting cycles of the property/casualty industry, the opinions of stock analysts and the reactions of investors may seem to be a side issue. But at least in the past 15 months investor interest has been a very important issue; the $8 billion in new capital has become readily and easily available to expand capacity only due to investors' faith in the industry's future—a faith somehow engendered despite 1985 underwriting losses of $24.6 billion.

The underwriting losses for 1985 represented 18.5% of premiums earned. A detailed comparative table reporting underwriting results by line and by industry segment appears below showing two years of premiums written and loss ratios by line. But for a quick comparison of underwriting results, the accompanying table of 1985 and 1984 combined ratios by line of business gives an instant picture of by-line underwriting trends. In viewing these combined ratios it should be noted that a certain portion of the improvements in most commercial lines must be attributed to a two-point overall decrease in underwriting expense ratios arising from the 22% increase of net premiums written in 1985. The industrywide pure loss ratio improved only two-tenths of a point. While the in-

Twelve Months, 1985 and 1984 Estimated Industry Combined Ratios by Line

Line of Business	1985	1984	Point Change
Commercial M.P.	121	136	−15
Comm. Auto Phys. Dam.	97	111	−14
Comm. Auto Liab.	129	143	−14
Comm. Auto Total	118	131	−13
Fire	98	110	−12
Inland Marine	95	106	−11
All Other Lines	112	121	−9
Auto Phys. Dam.	99	103	−4
P.P. Auto Phys. Dam.	99	101	−2
TOTAL ALL LINES	116	118	−2
Workers' Comp.	120	121	−2
Gen. Liability	150	151	−1
Total All Auto	112	112	0
Allied Lines	103	103	0
P.P. Auto Total	110	108	2
Auto Liability	121	119	2
Homeowners M.P.	110	107	3
Med. Malpractice	166	162	4
P.P. Auto Liab.	119	114	5

(continued)

1985 Underwriting Results By Line of Business

	< Net Prems. Written >		< - - - Pure Loss Ratio - - - >		
	12 Mos. 1985 (in 000's)	% Change 12 Mos. (85 vs 84)	12 Months 1985	1984	Point Chg. For 12 Mos. (85 vs 84)
INDUSTRY					
Fire	2,895,998	+22.21	54.80	64.39	-9.60
Allied Lines	1,586,401	+21.66	66.84	62.43	+2.41
Homeowners Multiple Peril	13,634,053	+5.52	70.93	66.90	+4.03
Commercial Multiple Peril	11,183,977	+46.67	72.55	81.43	-8.89
Inland Marine	3,002,641	+23.86	57.59	65.35	-7.75
Workers' Compensation	15,765,853	+14.69	81.28	81.08	+0.20
Medical Malpractice	2,288,420	+46.08	118.15	112.74	+5.41
Other Liability	10,135,789	+80.61	89.32	85.50	+3.82
Auto Liability	33,925,918	+18.95	83.69	80.57	+3.12
Auto Physical Damage	23,384,316	+15.24	66.49	68.54	-2.05
All Other Lines	16,152,709	+17.21	78.20	84.46	-6.26
Total of Above	131,935,875	+21.68	76.92	77.02	-0.09
No By Line Breakdown	10,569,146	+30.76	74.62	74.63	-0.01
Total of Industry Replies	142,505,021	+22.31	76.76	76.86	-0.10
Priv. Pass. Auto Liability	26,015,295	+13.82	82.34	77.04	+5.30
Commercial Auto Liability	6,252,643	+46.11	88.28	97.21	-8.93
No Breakdown	1,657,980	+19.74	85.83	89.94	-4.11
Total Auto Liability	33,925,918	+18.95	83.69	80.57	+3.12
Priv. Pass. Auto Phys. Dam.	19,016,584	+14.11	67.28	68.20	-0.92
Commercial Auto Phys. Dam.	3,100,605	+25.53	61.97	71.20	-9.24
No Breakdown	1,267,127	+9.58	65.37	67.99	-2.62
Total Auto Phys. Damage	23,384,316	+15.24	66.49	68.54	-2.05
Priv. Pass. Auto + Homeowners	58,665,932	+11.87	74.88	71.76	+3.12
No Breakdown Auto Total	2,925,107	+15.11	76.83	79.90	-3.07
All Other Lines Ex. No Split	70,344,836	+31.63	78.74	82.12	-3.38
Priv. Pass. Auto Total	45,031,879	+13.96	76.09	73.33	+2.76
Commercial Auto Total	9,353,248	+38.58	79.29	87.63	-8.35
Total All Auto	57,310,234	+17.41	76.62	75.59	+1.03
Total Non Auto	74,625,641	+25.18	77.16	78.20	-1.03
Medical Mal. & Other Liab.	12,444,209	+73.29	94.94	91.38	+3.56
CMP & Work Comp & Med Mal & Other Liab & Comm Auto	48,727,287	+38.09	82.19	84.46	-2.27
STOCK COMPANIES					
Fire	2,434,194	+23.67	53.98	65.84	-11.86
Allied Lines	1,280,763	+25.00	66.11	62.75	+3.36
Homeowners Multiple Peril	10,256,106	+6.14	70.86	66.09	+4.77
Commercial Multiple Peril	9,704,751	+45.27	72.68	81.11	-8.43
Inland Marine	2,708,120	+24.31	57.89	65.63	-7.76
Workers' Compensation	11,984,509	+12.60	80.95	81.25	-0.31
Medical Malpractice	1,620,121	+67.77	120.13	108.75	+11.38
Other Liability	8,959,216	+81.23	91.02	85.67	+5.34
Auto Liability	18,998,629	+20.26	83.88	82.46	+1.42
Auto Physical Damage	12,709,642	+15.26	64.03	66.68	-2.65
All Other Lines	10,611,164	+14.06	79.93	86.55	-6.62
Total of Above	90,847,213	+22.76	76.81	77.45	-0.64
No By Line Breakdown	8,213,717	+35.63	76.85	77.86	-1.00
Total of Stock Replies	99,060,930	+23.71	76.82	77.48	-0.66
MUTUAL COMPANIES					
Fire	461,804	+15.08	39.02	38.21	+0.81
Allied Lines	283,638	+8.34	59.24	61.16	-1.92
Homeowners Multiple Peril	2,360,937	+2.81	67.76	68.02	-0.26
Commercial Multiple Peril	1,479,226	+36.54	71.64	83.77	-12.12
Inland Marine	294,321	+19.82	34.85	62.85	-8.00
Workers' Compensation	3,781,344	+22.38	82.39	80.46	+1.93
Medical Malpractice	671,586	+60.12	130.10	135.74	-5.64
Other Liability	1,190,573	+76.09	77.18	84.24	-7.06
Auto Liability	11,328,959	+18.45	85.07	80.64	+4.44
Auto Physical Damage	8,108,645	+15.24	69.97	70.23	-0.26
All Other Lines	3,013,071	+27.23	76.48	82.57	-6.09
Total of Above	32,782,104	+20.01	77.84	77.10	+0.74
No By Line Breakdown	2,051,489	+16.70	67.29	63.87	+3.43
Total of Mutual Replies	34,833,593	+20.38	77.21	76.30	+0.91
RECIPROCALS					
Homeowners Multiple Peril	1,017,012	+5.67	79.00	72.46	+6.53
Medical Malpractice	396,713	+31.16	98.64	103.75	-5.12
Auto Liability	3,598,330	+13.94	78.39	70.73	+7.66
Auto Physical Damage	2,566,029	+15.25	67.62	72.47	-4.85
All Other Lines	728,474	+25.95	60.88	60.52	+0.36
Total of Above	8,306,558	+14.92	74.57	72.25	+2.31
No By Line Breakdown	303,940	+13.06	67.21	74.37	-7.16
Total of Reciprocal Replies	8,610,498	+14.85	74.32	72.33	+1.99

Note: These figures cover only the replies to the A.M. Best survey. For the stocks, results were furnished by companies representing approximately 98.8% of premiums; for mutuals, 98.3%; for reciprocals, 98.4%, and for the total industry, 98.0%.

dustrywide combined ratio was 116, those for stock companies, mutuals and reciprocals respectively were 118, 112 and 113.

This ranking of 1985 combined ratios by degree of change serves to focus on two areas of business which enjoyed substantial increases in net premiums written. Premiums for commercial multiple peril increased 47%; total commercial auto premiums were up 39%. The other two top gainers in premiums, however, general liability (up 81% in premiums) and medical malpractice (up 47%) failed to improve in terms of year-end combined ratios, underscoring the problems still presented by these lines—and witnessing the effects of continuing reserve increases directed at these problem areas.

National attention more and more has become focused on the losses and resultant problems of availability and affordability of general liability coverage. Since 1979, when competition for commercial lines premiums led to price-cutting anachronistic with the escalation of liability losses, the general liability line progressively has become a major problem for insurance underwriters, agents and brokers, commercial insureds, and now for society as a whole. The situation finally led to the industry's heroic efforts to: (a) raise commercial general liability premiums by 81% in 1985; (b) introduce a new claims-made CGL policy which limits coverage periods but avoids many of the court-imposed pitfalls of the traditional occurrence-based coverage; (c) exclude from CGL coverage common and uncommon pollution liabilities and other predictable high technology exposures; and (d) concentrate on promulgation of reforms of the tort liability system to reduce incentives and rewards for abuses by an increasingly litigious society.

The combined ratio for workers' compensation improved less than two points from 1984 to 1985, but despite this small improvement in ratio, the underwriting loss actually increased by $200 million to $3.3 billion. A 15% increase in premiums written and a 13% increase in premiums earned kept the loss ratio virtually static, while lower dividends to policyholders and an improved underwriting expense ratio arising from the gain in premiums written produced a two-point improvement of the combined ratio.

The listing of combined ratios by line of business is an excellent guide for displaying the relative *rates* of profitability (or, more likely, unprofitability) by line of business. But to view the relative magnitude of underwriting losses by line, it helps to view a table of underwriting losses by whole dollars. The following table provides a clearer picture of where the property/casualty insurance industry's underwriting loss dollars are going.

1985 Underwriting Losses by Line of Business

Line	Loss ($000)	% Total
Total All Auto	7,707,423	31.4
All Auto Liab.	7,588,835	30.9
All Auto Phys. Dam.	118,588	0.5
Total P.P. Auto	5,478,275	22.3
Total Comm. Auto	2,229,148	9.1
Miscellaneous Liability	6,831,870	27.8
General Liability	5,266,093	21.4
Medical Malpractice	1,565,777	6.4
Workers' Comp.	3,327,122	13.5
Comm. Multi Peril	2,730,152	11.1
All Other Lines	2,308,024	9.4
Homeowners	1,617,983	6.6
Allied Lines	96,312	0.4
Fire	40,473	0.2
Inland Marine	(99,359)	-0.4
Total Industry	24,560,000	100.0
Commercial & Other	17,463,742	71.1
Personal Lines	7,096,258	28.9

Liability Is Not the Only Problem

The miscellaneous liability line (medical malpractice and general liability) have gained notoriety as the source of the industry's problems, and indeed, if added to commercial multiple peril which includes a significant amount of liability losses, produces an underwriting deficit in the range of $8 billion. But the underwriting loss of $7.7 billion for all auto insurance should merit almost equal concern among insurers. This is due to the fact that investment income on long-tailed liability lines has the potential to offset unprofitability, if all else is equal.

Leading the losers among the auto sublines is private passenger auto liability, which produced almost all of the $5.5 billion of personal auto underwriting losses in 1985. Although annual combined ratios for private passenger auto liability have increased moderately (from 110 to 118) over the past four years, the sheer volume of this line's premiums (20% of the industry's total) produces losses worthly of more concern than they apparently are receiving. The growth of these losses becomes more vivid when one sees that 1985's fourth quarter combined ratio for private passenger auto liability was 124, compared with 1984's fourth quarter combined ratio of 117.

Whither Personal Lines?

This question of private passenger auto losses gives rise to further inquiry in the comparison of personal and commercial lines. Personal lines produced 29% of underwriting losses in 1985 while contributing 45% to the industry's net premiums written. Yet, aside from medical malpractice, personal auto and homeowners had the greatest increases in combined ratios, as shown in the combined ratio table above. More immediately, the fourth quarter, 1985 combined ratio for all personal lines was 111.6, compared with a 108.4 for the fourth quarter of 1984. Personal lines also were among those with the lowest growth of premiums: 12% compared with 22% for all property/casualty lines. Is anyone doing anything about this?

A comparative (but unscientific) review of three recent months' filings with the insurance departments of five states in the East, Midwest and West shows a much higher than usual volume of filings for personal lines rate increases. Although there is a high rate of filings, they represent a modest increase. Observed filings for rate hikes are asking for a median 9% increase for homeowners and 11% for private passenger auto coverages. Personal lines combined ratios below 100 obviously are not the immediate objective.

Based upon existing trends, the outlook for personal lines is for gradually increasing losses until a crisis occurs among some smaller insurers. Although the pressure for higher rates may be evident to many, the "big five" personal lines writers (Allstate, State Farm, USAA, GEICO and SAFECO) reported respectable profits and reasonable growth of surplus and premiums for 1985. As long as these market share leaders find no urgent need to raise rates substantially, it becomes difficult for their smaller competitors to price their products too much higher. A change in the fortunes of personal lines may take a while; the competitive state of the marketplace will not permit it to be an abrupt change.

Commercial Lines Outlook

Commercial lines underwriters now are emerging from a miserable seven years of competitive underpricing, surprises by the tort liability system and diminishing availability of high returns on interest-based investments. Grateful for survival (about 30 became insolvent in 1985) they also are thankful for economic and financial market conditions providing increased capacity; a tight, insurance seller's marketplace; and a definable shift of public opinion favoring enactment of tort liability system reforms.

Our projections for 1986 results indicate that 1986 will be a watershed year, one in which many property/casualty insurers will continue to channel increasing income toward stronger reserves in anticipation of a still unsure future. (Unsure both are the degree of future liability losses and the future of bond markets where most loss reserves are invested.) It is mainly for this reason that our projections for 1986 on the final table are conservatively restrained, showing a combined ratio of 113 and an underwriting loss not much lower than 1985's. (For 1985, loss reserves of the industry increased $19.4 billion or 14% to $153.1 billion.) Following this watershed period of part or all of 1986, the property/casualty industry will be poised to enter an indefinite period of unquestioned profitability—maybe, and depending...

Dangers of Turning a Corner

Although the underwriting cycle began turning with premium increases in the fourth quarter of 1984 and conditions and trends since have fallen into place for a future period of prosperity for the property/casualty industry, this environment of rapid change creates dangers that things may go awry. Some seeds already are sown for changes that might interfere with fulfillment of directions now tentatively set for the industry.

Higher prices may become counterproductive. To a point, higher rates for poor or uncertain risks serve the purpose of insurer profitability. Beyond a scarcely definable point, higher rates become counterproductive, driving good risks out of the traditional market and creating adverse selection among the remaining risks. In the brief period in which general liability rates have increased 81%, a number of plans have been formulated to take premiums offshore or otherwise out of the traditional market. Also, albeit haltingly, Congress has been working to expand provisions of the Risk Retention Act.

New regulation may be provoked. The current unavailability and unaffordability of liability coverage is viewed alternatively as a "liability crisis" and an "insurance crisis." Regulators' MAP plans are an initial reaction to unavailability. Public despair over inconveniences caused by unavailability or unaffordability of insurance coverages may provoke stronger regulatory or legislative measures.

Premature overcompetition may emerge. Although this report largely has dealt with industry averages, it never can be denied that some companies have better results than others. The first insurers attaining satisfactory profits in the turn of the cycle could initiate a new competitive cycle or new, inexperienced capacity could be attracted by prospects of profitability. Price might not be the only factor in the next cycle; conditions of the controversial new claims-made CGL form could complicate elements of competitiveness for underwriters, producers and buyers of commercial coverages.

Catastrophe threats increase. Increasing commercial and residential development of vulnerable areas increase the potential for natural catastrophe losses, as does the increasing potential of technology-caused unnatural supercatastrophes. Historically, catastrophe losses within 3% of total annual losses have been manageable by the industry, with reinsurance playing its most important role in such cases. But greater losses become increasingly possible and may tax the resources of reinsurers just now recovering from the same difficulties endured by primary carriers.

Another asbestosis may emerge. There was no reason to believe, at one time, that a common insulating material might become identified as a major health hazard and a cause of financial distress to all involved with it. Similar developments involving now-unsuspected substances could emerge at any time.

Dominoes could fall. The now delicately balanced insurance industry comprises companies leveraged to varying degrees and frequently having their fates intertwined through syndicates, pooling arrangements, reinsurance and responsibilities to guaranty funds through which the winners must subsidize the losers. Despite the imminence of prosperity for the industry, the rate of insolvencies remains high.

In predicting the future of the fast-changing property/casualty insurance arena, one is faced with questions and qualifications at every turn. The future directions of the stock and bond markets are entirely unpredictable, for example. For this reason, our projection of 1986 operating results on the accompanying six-year table will remain subject to revision each quarter, as we monitor and comment upon the industry's progress toward much-needed better times. □

1981-1985 Property/Casualty Operations
— With Projections for 1986 —

Property/Casualty Industry Results—All Lines
(in $ millions)

Year	Net Prem Written	Net Prem Earned	Losses & Expenses Incurred: Pure Losses +	Loss Adj Exp (LAE) =	Losses & LAE +	Und Exp =	Total Expend	Und Gain/Loss Pre Divs −	Divs to Pol =	Und Gain/Loss After Divs +	Net Invest Income +	Other Income =	Pre-tax Op Income
1981	98,806	96,998	64,687	9,690	74,378	27,128	101,506	−4,508	1,816	−6,324	13,248	−262	6,662
1982	103,116	101,147	70,014	10,575	80,589	28,999	109,588	−8,440	1,976	−10,416	14,899	−407	4,076
1983	107,803	105,787	74,623	11,459	86,082	30,796	116,878	−11,091	2,194	−13,285	15,784	−308	2,191
1984	117,744	114,257	87,917	12,731	100,647	32,981	133,628	−19,371	2,084	−21,455	17,448	46	−3,961
1985*	144,035	132,805	102,027	15,628	117,654	37,511	155,165	−22,361	2,199	−24,560	19,720	−120	−4,960
1986**	175,000	163,000	122,400	18,700	141,100	43,700	184,800	−21,800	2,400	−24,200	22,800	−100	−1,500

Property/Casualty Industry Ratios and Changes—All Lines

Year	Annual Ratios: Pure Loss	LAE	Loss & LAE	Und Exp	Combined Before Divs	Divs to Pol	Combined After Divs	Percent Change from Prior Year: NPW %	NPE %	Pure Loss	LAE %	Loss & LAE	Und Exp	Divs to Pol	Total Expend + Divs
1981	66.7	10.0	76.7	27.5	104.1	1.9	106.0	3.8	3.9	6.2	8.6	6.5	7.3	12.3	6.8
1982	69.2	10.5	79.7	28.1	107.8	2.0	109.8	4.4	4.3	8.2	9.1	8.4	6.9	8.8	8.0
1983	70.5	10.8	81.4	28.6	109.9	2.1	112.0	4.6	4.6	6.6	8.4	6.8	6.2	11.0	6.7
1984	77.0	11.1	88.1	28.0	116.1	1.8	117.9	9.2	8.0	17.8	11.1	16.9	7.1	−5.0	14.0
1985*	76.8	11.8	88.6	26.0	114.6	1.7	116.3	22.3	16.2	16.1	22.8	16.9	13.7	5.5	16.0
1986**	75.1	11.5	86.6	25.0	111.5	1.5	113.0	21.5	22.7	20.0	19.7	19.9	16.5	9.1	19.0

*Revised estimate.
** Estimated.

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ITEM #5:

COLLECTIVE FINANCIAL DATA SENT TO COMPANIES

First-Quarter 1986 Analysis

Operating Results

Insurance Services Office Inc.

June 4, 1986

Net Income

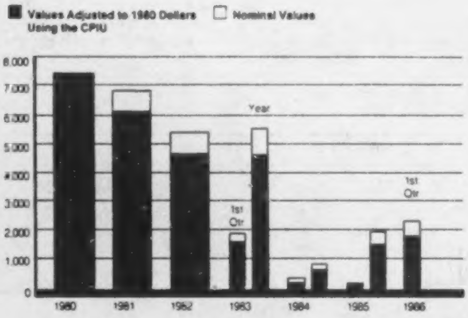
The property/casualty insurance industry's consolidated net after-tax income totaled $2.3 billion for the first quarter of 1986. This represented a significant increase from the net income of $172 million recorded in the first quarter of 1985, the second lowest quarterly net income figure recorded in the last ten years.

The net income was predominantly the result of $1.6 billion in realized capital gains from the sale of assets, reflecting the surge in stock and bond prices over the last year, but net income also included positive pretax operating *income* of $474 million. This followed nine consecutive quarters of pretax operating *losses*.

The GAAP-adjusted return on net worth for the industry in the first quarter of 1986 was 3%, an improvement over the 1% return for the first quarter of 1985. (These return on net worth figures are not annualized. They are the ratio of the GAAP-adjusted first-quarter returns to end-of-quarter surplus.)

The 1985 and 1986 figures in this analysis are consolidated estimates for the entire property/casualty industry based on the experience of insurer groups that report to ISO and the NAII, representing an estimated 97% of the total industry premium. The 1980-1984 annual industrywide data is from A.M. Best Company.

Net Income After Taxes
($ Millions)



Income Summary
(Dollar Amounts Displayed in Millions)

	Net Underwriting Gain (Loss)* Before Taxes	Underwriting Gain (Loss) as a Percent of Earned Premium	Consolidated Net Investment Gain (Loss)† Before Taxes	Consolidated Net Income After Taxes‡
1980	($3,334)	(3.6%)	$11,586	$7,437
1981	(6,288)	(6.4)	13,524	6,870
1982	(10,290)	(10.1)	15,479	5,485
1983	(13,322)	(12.4)	18,083	5,570
1984	(21,477)	(18.7)	20,723	628
1985	(24,738)	(16.6)	24,826	1,958
1986 (1st Qtr.)	**($4,720)**	**(12.5%)**	**$6,818**	**$2,278**

* Net Underwriting Gain or Loss = Net Earned Premium *minus* Incurred Losses and Loss Adjustment Expenses, Other Underwriting Expenses, and Policyholder Dividends

† Net Investment Gain or Loss = Net Realized Capital Gains (Losses) *plus* Net Investment Income

‡ Net Income After Taxes = Net Underwriting Gain (Loss) *plus* Net Investment Gain (Loss) *plus* Miscellaneous Income *minus* Taxes Incurred

Results by Type of Insurer

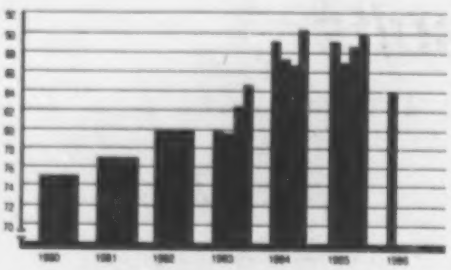
Industrywide, the first-quarter 1986 combined ratio was 109.9, a 7.4 point improvement over the first-quarter 1985 combined ratio of 117.3. The greatest improvement was for stock insurers, whose combined ratio dropped 8.4 points. Mutuals followed with a 6.2 point decrease, and reciprocal and other companies with a 5.0 point decrease. Stock insurers, as a result of their greater concentration in commercial lines, also posted the greatest written premium growth from the comparable quarter one year earlier at +30.3%, followed by reciprocals and others at +22.0%, and mutuals at +20.9%.

	Loss Ratios*		Expense Ratios†		Dividend Ratios‡		Combined Ratios§		Surplus ($ Billions)		Written Premium Growth
Industry Segments	**1st Qtr. 1986**	**1st Qtr. 1985**	**1st Qtr. 1986**	**1st Qtr. 1985**	**1st Qtr. 1986**	**1st Qtr. 1985**	**1st Qtr. 1986**	**1st Qtr. 1985**	**1st Qtr. 1986**	**Year-End 1985**	**1st Qtr. 1986 1st Qtr. 1985**
Stock Insurers	83.6%	88.9%	26.3%	29.0%	1.1%	1.5%	111.0%	119.4%	$51.0	$47.0	+30.3%
Mutual Insurers	84.6	89.6	21.5	22.5	1.2	1.3	107.2	113.4	26.3	24.5	+20.9
Reciprocal & Other Insurers	85.6	87.9	20.0	20.8	4.2	6.1	109.8	114.8	4.9	4.6	+22.0
Total	**84.0%**	**89.0%**	**24.5%**	**26.5%**	**1.3%**	**1.7%**	**109.9%**	**117.3%**	**$82.2**	**$76.1**	**+26.9%**

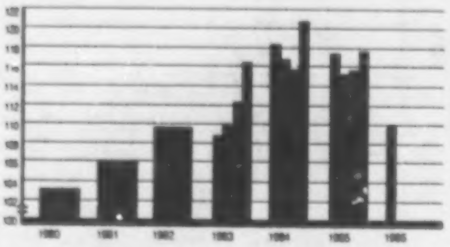
* Loss Ratio = Incurred Losses and Loss Adjustment Expenses *divided by* Net Earned Premium
† Expense Ratio = Other Underwriting Expenses *divided by* Net Written Premium
‡ Dividend Ratio = Policyholder Dividends *divided by* Net Earned Premium
§ Combined Ratio = Loss Ratio *plus* Expense Ratio *plus* Dividend Ratio

Underwriting

Loss Ratios



Combined Ratios



The underwriting loss for the first quarter of 1986 was $4.7 billion (12.5% of earned premium), showing improvement over both the $5.9 billion loss (19.8% of earned premium) in the first quarter of 1985 and the $6.9 billion loss (18.4% of earned premium) in the fourth quarter of 1985.

According to the Property Claim Services of the American Insurance Services Group, Inc., catastrophe losses in the first quarter of 1986 totaled $296 million, compared with $612 million in the first quarter of 1985 and $287 million in the fourth quarter of 1985.

The loss and loss adjustment expense ratio for the first quarter was 84.0, five points better than the 89.0 for the first quarter of 1985. The combined ratio of 109.9 for the first quarter of 1986 improved dramatically over the 117.3 combined ratio for the first quarter of 1985 and was the lowest combined ratio since the first quarter of 1983.

Written premiums for the first quarter totaled $41.8 billion, up 26.9% from $32.9 billion in the first quarter of 1985. This maintained the high level of premium growth experienced in 1985, which showed increases of 15.3%, 18.4%, 22.9%, and 29.5% in the first, second, third and fourth quarters respectively. However, the first-quarter 1986 written premium growth was slightly lower than that for fourth-quarter 1985.

Incurred losses for the first quarter totaled $31.7 billion, up 18.3% from $26.8 billion in the first quarter of 1985. The growth rates in losses for 1985 were 10.7%, 12.6%, 19.1% and 22.5% for the first, second, third and fourth quarters respectively.

Loss and loss adjustment expense reserves grew to $160.2 billion in the first quarter of 1986, an increase of 4.1% from year-end 1985 and 17.4% from the first quarter of 1985. A year ago, the first-quarter 1985 increase in loss and loss adjustment expense reserves was only 1.1% above fourth-quarter 1984 and 8.9% above first-quarter 1984.

Combined Ratio and Its Components

	Loss Ratio	Expense Ratio	Dividend Ratio	Combined Ratio
1980	74.9%	26.5%	1.7%	103.1%
1981	76.8	27.4	1.8	105.0
1982	79.8	27.9	1.9	109.6
1983	81.5	28.4	2.1	112.0
1984	88.2	27.9	1.8	118.0
1985	88.7	26.1	1.7	116.4
1986 (1st Qtr.)	84.0%	24.5%	1.5%	109.9%

Premiums, Losses, and Reserves

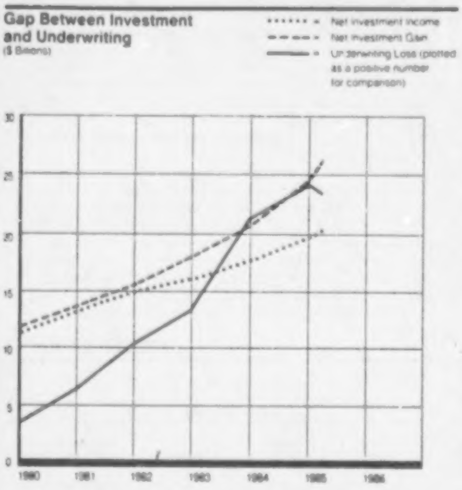
($ Millions)

	Written Premium	Percent Change	Earned Premium	Percent Change	Incurred Losses (including LAE)	Percent Change	Loss Reserves (including LAE)	Percent Change
1980	$ 95,702	6.1%	$ 93,880	7.9%	$ 70,284	10.6%	$ 92,493	14.0%
1981	99,373	3.8	97,385	3.8	74,904	6.6	102,422	10.7
1982	104,038	4.7	102,070	4.6	81,410	8.7	111,959	9.3
1983	109,247	5.0	107,186	5.0	87,399	7.4	122,715	9.6
1984	118,581	8.6	115,010	7.3	101,448	16.1	134,926	10.0
1985	144,336	21.7	133,246	15.9	119,127	16.4	153,891	14.1
1986 (1st Qtr.)*	$41,773	26.9%	$37,713	25.4%	$31,680	18.3%	$160,226	17.4%

* Percent Change = first-quarter 1986 - first-quarter 1985.

Investment vs. Underwriting

Gap Between Investment and Underwriting
($ Billions)



The industry's pretax operating income of $474 million in the first quarter of 1986 compares with a pretax operating loss in the first quarter of 1985 of $1.4 billion. The major components of this quarter's operating income were a pretax underwriting loss of $4.7 billion and pretax net investment income of $5.2 billion.

The first quarter 1986 consolidated investment gain was $6.8 billion, consisting of $5.2 billion of investment income and $1.6 billion of realized capital gains. The comparable first quarter 1985 consolidated investment gain was $5.6 billion, consisting of $4.6 billion of investment income and $1.0 billion of realized capital gains.

Realized capital gains have become an increasingly important component of net investment gain, rising from 2% of net investment gain in 1981, to 22% in 1985 and to 23% in the first quarter of 1986. For the first quarter of 1986, realized capital gains represented 70% of net income after taxes. For a further analysis of capital gains, refer to page 4.

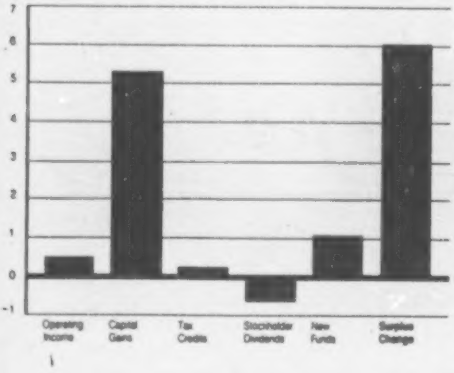
Pre-Tax Operating Income
($ Millions)

	Net Investment Gain	Net Investment Income	Net Realized Capital Gains	Net Pre-Tax Underwriting Gain (Loss)	Pre-Tax Operating Income (Loss)*
1980	$11,586	$11,063	$523	($3,334)	$7,729
1981	13,524	13,246	278	(6,288)	6,960
1982	15,479	14,907	572	(10,290)	4,617
1983	18,083	15,973	2,110	(13,322)	2,661
1984	20,723	17,660	3,063	(21,477)	(3,817)
1985	24,826	19,465	5,361	(24,738)	(5,403)
1986 (1st Qtr.)	**$6,818**	**$5,230**	**$1,588**	**($4,720)**	**$474**

* Pre-Tax Operating Income = Net Underwriting Gain or Loss plus Net Investment Income Earned plus Miscellaneous Other Income

Analysis of Surplus Change

Surplus Change and its Components First-Quarter 1986
($ Billions)



The consolidated surplus for the industry was $82.2 billion as of March 31, 1986—an increase of 8% from year-end 1985. The $6.1 billion increase in surplus, despite only $0.5 billion of operating income, was primarily a result of $3.7 billion in unrealized capital gains, $1.6 billion in realized capital gains and a $1.1 billion infusion of new funds.

Capital gains continue to be a strong contributor to surplus, accounting for 87% of the total surplus increase this quarter. New funds, at $1.1 billion, remain high.

Net Income and Surplus Change First-Quarter 1986
($ Billions)

Operating Income	$0.5
Realized Capital Gains	1.6
Tax Credits	0.2
Subtotal: Net Income	**2.3**
Unrealized Capital Gains	3.7
New Funds	1.1
Stockholder Dividends	(0.6)
Miscellaneous Surplus Change	(0.4)
Total: Surplus Change	**$6.1**

Analysis of Capital Gains

Realized and unrealized capital gains for the industry each reached all-time highs in 1985, $5.4 billion and $5.1 billion respectively. The large realized capital gains in both 1984 and 1985 were sufficient to offset otherwise negative after-tax net income in those years. Both realized and unrealized capital gains continued at abnormally high levels in the first quarter of 1986, totaling $1.6 billion and $3.7 billion respectively. The total capital gains (the sum of realized and unrealized capital gains) in the quarter were in fact larger than those of any entire year except 1985.

Historically, realized capital gains have been a relatively small contributor to net income after taxes. During the 18-year period, 1966-1983, realized capital gains never exceeded 55% of net income and averaged 15% of net income. In each of the last two years, however, due to extremely poor operating results, realized capital gains have exceeded net income after taxes.

The most important sources of realized capital gains (losses) have been—from largest to smallest—common stock, bonds, and preferred stock. While the industry has earned increasing amounts of capital gains through the sale of common stock, 1985 marked the first year since at least 1979 when the sale of bonds contributed capital gains rather than capital losses. ISO estimates that the industry earned $1.5 billion in realized capital gains from the sale of bonds in 1985, a year that witnessed a sustained decline in interest rates from the relatively high levels of the preceding years.

While bonds are an important source of *realized* capital gains (losses), they have been a small source of *unrealized* capital gains (losses). This is a consequence of statutory accounting which mandates that, in general, bonds be kept at amortized value rather than market value. The single most important source of unrealized capital gains (losses) continues to be common stock.

Despite the large realized capital gains in the past three years, total capital gains as a percent of assets did not set any new records, even in 1985. Although the 1985 ratio of total capital gains to assets of 3.4% was large compared to the 20-year average of 0.3%, slightly higher ratios of total capital gains to assets were recorded in two of the past 20 years—1972 and 1975. The large total capital gains of $15.8 billion over the past five quarters accounted for nearly 90% of the increase in industry surplus—$18.4 billion—in the same period.

Realized and Unrealized Capital Gains by Type of Asset 1979-1985

($ Millions)

	Realized Capital Gains				Unrealized Capital Gains			
	Common Stock	Preferred Stock	Bonds	Total Realized Capital Gains*	Common Stock	Preferred Stock	Bonds	Total Unrealized Capital Gains*
1979	$630	($79)	($289)	$300	—	—	—	$2,030
1980	1,323	(187)	(728)	533	—	—	—	4,274
1981	1,630	(175)	(1,377)	276	($2,128)	($71)	($11)	(2,656)
1982	1,731	(188)	(908)	572	(3,167)	472	(138)	2,908
1983	3,333	(70)	(1,381)	2,110	2,114	85	(474)	1,358
1984	3,280	(61)	(627)	3,083	(2,788)	(32)	(27)	(2,879)
1985†	$3,500	$30	$1,500	$5,361	$4,800	$800	$300	$5,130

* Total includes other sources—mainly real estate—in addition to common stock, preferred stock and bonds.

† Figures for 1985 are estimates based on data for companies that represent 52% and 30% of total realized and total unrealized capital gains, respectively.

Capital Gains
1966-1985

	Realized Capital Gains ($ Millions)	Realized Capital Gains as a Percent of Assets	Total Capital Gains ($ Millions)	Total Capital Gains as a Percent of Assets	Total Capital Gains as a Percent of Surplus
1966	$348.0	0.83%	($1,661.8)	(3.96%)	(10.69%)
1967	157.0	0.34	1,142.0	2.46	7.72
1968	417.2	0.82	1,280.2	2.95	7.98
1969	681.5	1.34	(1,737.5)	(3.35)	(12.44)
1970	150.1	0.26	(322.9)	(0.56)	(2.08)
1971	184.0	0.28	1,617.0	2.43	8.46
1972	293.0	0.38	3,116.0	3.99	13.08
1973	276.0	0.35	(4,083.0)	(4.91)	(19.09)
1974	(163.0)	(0.20)	(6,163.0)	(7.57)	(37.88)
1975	141.0	0.15	3,486.0	3.73	17.68
1976	290.0	0.26	3,044.0	2.72	12.36
1977	329.3	0.26	(753.2)	(0.59)	(2.57)
1978	56.5	0.04	488.7	0.31	1.32
1979	300.5	0.17	2,330.9	1.34	5.49
1980	532.6	0.27	4,806.9	2.43	9.21
1981	276.0	0.13	(2,380.1)	(1.13)	(4.44)
1982	571.8	0.25	3,480.3	1.50	5.76
1983	2,109.9	0.85	3,468.1	1.38	5.29
1984	3,083.2	1.16	203.8	0.08	0.32
1985	$5,360.6	1.75	$10,494.2	3.42	13.76
Average		0.46%		0.31%	0.96%

For more information, contact Michael Fusco, Senior Vice President and Actuary, Insurance Services Office, Inc., 175 Water Street, New York, New York 10038. Phone: (212) 487-5020

ITEM #6:

SPECIAL PROJECT ON "EXPERIENCE DATA BY LINES OF INSURANCE"

COUNTRYWIDE RESULTS FOR SELECTED COMMERCIAL LIABILITY CLASSES

BACKGROUND

Many regulatory and legisative bodies have conducted inquiries over the past several months into some affordability and availability issues for certain commercial liability classes of insurance. These inquiries have usually focused on municipalities, other governmental subdivisions, liquor liability and day care centers. The purpose of this document is to provide the most recent countrywide premium and loss information for these and other commercial liability classes.

ISO ACTION

ISO has provided countrywide and/or state statistical plan data from all our reporting carriers to various state commissions including, most recently, commissions in Illinois, New Jersey and New York. Tables and summary graphs of the type of countrywide experience presented are in Sections Two and Three of this document.

ISO will continue to respond to similar requests for such data, as may be appropriate. Furthermore, individual state summary exhibits will be prepared and provided to regulators and other interests as requested and appropriate. The countrywide information is provided herein so that any insurer responding to inquiries for its own data will be aware of the contents, specifications and format of the material ISO has provided.

SPECIAL NOTICE

Much of this business is written by markets not reporting to ISO or under programs that do not capture detailed information.

PERSON TO CONTACT

Any questions or comments, including the availability of specific state information, may be directed to:

Michael Fusco
Senior Vice President & Actuary
Insurance Services Office, Inc.
175 Water Street
New York, New York 10038
(212) 487-5020

DESCRIPTION OF THE STATISTICAL RESULTS

DATA INCLUDED

Each exhibit presents the countrywide statistical data of one group of risks. The experience of both monoline and multiline policies written under ISO programs or essentially similar programs is included. These exhibits separately compile the five most recent policy years (years ending December 31, 1980 through 1984), and show five-year totals.

Only Owners, Landlords and Tenants (OL&T) Bodily Injury Liability or Liquor Liability experience reported to ISO under the ISO Commercial Statistical Plan (CSP) and the intermediate level of the Commercial Minimum Statistical Plan (CMSP) is included. This includes the experience of all ISO reporting companies except for the very smallest, which may elect to report under the mini level of CMSP. The specific ISO class codes used are listed on each exhibit.

DEFINITIONS

Total Limits Earned Premium is the actual premiums collected for policies in the indicated policy years. These premiums are *not* adjusted either for ratemaking considerations such as subsequent rate changes, or to eliminate the effect of package or other rating modifications.

Incurred Losses are the actual losses paid for the policies plus the reserves for unpaid losses as of March 31, 1985. The losses have been adjusted to ultimate settlement level using the countrywide loss development factors for OL&T manual ratemaking classes. These factors adjust primarily for the later emergence of claims that had not been reported by March 31, 1985. The losses were also adjusted to include unallocated loss adjustment expenses, based on the standard factor developed from all General Liability experience. Any deviations from these average values will result in inaccuracies in the estimated ultimate values of losses and loss adjustment expenses. Losses have *not* been adjusted for subsequent changes in cost levels.

Basic Limits Incurred Losses include the first $25,000 of each loss and all loss adjustment expenses. *Excess Limits Incurred Losses* are that part of each loss in excess of $25,000, but do not include loss adjustment expense.

The *Number of Incurred Claims* is reported claims adjusted to ultimate settlement levels based on development factors derived from the countrywide experience of OL&T manual ratemaking classes.

DEFINITIONS

The Loss and Loss Adjustment Expense Ratio compares the total limits incurred losses and loss adjustment expenses with the total limits collected earned premiums. This ratio calculates the dollars of losses and loss adjustment expenses incurred per dollar of premium collected. The ratio has not been adjusted to include company operating expenses.

DATA LIMITATIONS

Any analysis that uses the data shown in these exhibits must consider the limitations of the data. The reported experience for these classes is often quite limited, so the credibility of the results must be carefully examined.

Data for these classes are also available on a state basis. The state data are directly comparable to the countrywide. Because of the smaller volume, credibility is a more important consideration when examining data from a single state than when the data are considered on a countrywide basis. Distortions in the state data may also occur because of the absence from the ISO database of the state's major writers of that class. Furthermore, an individual state's data may not yet reflect national trends which will transcend state boundaries, such as landmark court decisions in other jurisdictions.

The experience reported to ISO for these classes does not include the entire market for these types of risks (for example, an insurer that has developed an independent program using a different exposure base or coverage provisions). Similarly, excess or deductible liability insurance cannot be included. Also, some carriers, such as the excess and surplus lines carriers that have written much of the liquor liability market, do not report statistics to ISO. Because of these exclusions, the experience reported here may not be representative of the entire market.

GENERAL LIABILITY INSURANCE
ALL OWNERS, LANDLORDS AND TENANTS CLASSES
MONOLINE AND MULTILINE COMBINED

Owners, Landlords and Tenants includes coverage arising from liability claims for bodily injury and medical payments arising out of the ownership, maintenance or use of the covered premises and incidental operations. The remaining exhibits in this report, except for Liquor Liability, detail specific classifications of OL&T.

POLICY YEAR ENDED	TOTAL LIMITS EARNED PREMIUM	BASIC LIMITS INCURRED LOSSES	EXCESS LIMITS INCURRED LOSSES	NUMBER OF INCURRED CLAIMS	LOSS & LOSS ADJUSTMENT EXPENSE RATIO
12/31/80	$ 502,589,481	$ 318,541,483	$ 138,366,733	57,680	90.9%
12/31/81	652,083,610	450,110,341	218,620,521	76,396	102.6%
12/31/82	719,568,955	600,871,615	271,239,890	99,611	121.2%
12/31/83	774,480,450	683,155,842	352,750,271	104,405	133.8%
12/31/84	762,267,289	742,975,287	436,313,901	106,307	154.8%
TOTAL	$3,410,989,785	$2,795,654,568	$1,417,291,316	444,399	123.5%

GENERAL LIABILITY INSURANCE
MUNICIPAL CLASSES*
MONOLINE AND MULTILINE COMBINED

This exhibit includes all OL&T classes that are strictly municipal in nature. Sheet 2A summarizes particular groups of municipal classes. Their experience is also included here. Certain exposures, such as housing projects, bus stations and bridges are excluded from these classes, and are shown in a separate exhibit on Sheet 3.

POLICY YEAR ENDED	TOTAL LIMITS EARNED PREMIUM	BASIC LIMITS INCURRED LOSSES	EXCESS LIMITS INCURRED LOSSES	NUMBER OF INCURRED CLAIMS	LOSS & LOSS ADJUSTMENT EXPENSE RATIO
12/31/80	$ 35,296,627	$ 31,251,906	$ 15,719,085	4,390	133.1%
12/31/81	57,007,556	48,984,959	30,810,927	6,460	140.0%
12/31/82	66,407,102	67,818,339	39,395,319	8,527	161.4%
12/31/83	78,059,122	96,319,947	69,406,579	11,630	212.3%
12/31/84	67,692,458	100,679,876	73,688,299	12,125	257.7%
TOTAL	$304,462,865	$345,055,027	$229,020,209	43,132	188.6%

*Classes Included

82113	Public High Schools or Junior Colleges
82116	Schools - Not otherwise classified
91250 - 91263	Governmental Subdivisions
92151 92153 93151	Streets and Roads
93050	Governmental Composite Rated Risks
93111	Government Employees
93155	Play Streets
93164	Municipal Permits
93221	Elementary, Kindergarten or Junior High Schools - Public

GENERAL LIABILITY INSURANCE

STREETS AND ROADS (CLASSES 92151, 92153 AND 93151)
MONOLINE AND MULTILINE COMBINED

POLICY YEAR ENDED	TOTAL LIMITS EARNED PREMIUM	BASIC LIMITS INCURRED LOSSES	EXCESS LIMITS INCURRED LOSSES	NUMBER OF INCURRED CLAIMS	LOSS & LOSS ADJUSTMENT EXPENSE RATIO
12/31/80	$ 6,874,941	$10,080,648	$ 5,124,326	1,307	221.2%
12/31/81	7,538,187	14,461,824	8,575,478	1,654	305.6%
12/31/82	7,328,564	1[illegible],623,471	13,505,009	1,818	424.8%
12/31/83	6,660,170	17,677,843	16,507,406	1,921	513.3%
12/31/84	5,652.493	17,050,818	13,603,390	1,868	542.5%
TOTAL	$34,05[illegible],355	$76,894,604	$57,315,609	8,568	394.1%

PUBLIC SCHOOLS (CLASSES 82113, 82116, AND 93221)
MONOLINE AND MULTILINE COMBINED

POLICY YEAR ENDED	TOTAL LIMITS EARNED PREMIUM	BASIC LIMITS INCURRED LOSSES	EXCESS LIMITS INCURRED LOSSES	NUMBER OF INCURRED CLAIMS	LOSS & LOSS ADJUSTMENT EXPENSE RATIO
12/31/80	$12,336,307	$ 10,440,549	$ 3,600,852	1,807	113.8%
12/31/81	17,130,091	15,196,239	7,081,218	2,595	130.0%
12/31/82	19,234,384	19,856,327	7,124,042	3,106	140.3%
12/31/83	26,392,414	36,820,657	22,929,399	4,844	226.4%
12/31/84	24,262,371	39,878,934	23,557,466	5,100	261.6%
TOTAL	$99,355,567	$122,192,706	$64,292,977	17,452	187.7%

GOVERNMENTAL SUBDIVISIONS (CLASSES 91250 - 91263)
MONOLINE AND MULTILINE COMBINED

POLICY YEAR ENDED	TOTAL LIMITS EARNED PREMIUM	BASIC LIMITS INCURRED LOSSES	EXCESS LIMITS INCURRED LOSSES	NUMBER OF INCURRED CLAIMS	LOSS & LOSS ADJUSTMENT EXPENSE RATIO
12/31/81	$13,966,938	$ 8,076,986	$ 6,877,043	886	107.1%
12/31/82	26,561,019	18,588,450	10,916,487	2,236	111.1%
12/31/83	29,064,201	25,595,258	16,304,092	3,079	144.2%
12/31/84	25,970,257	31,422,775	24,746,253	3,627	216.4%
TOTAL	$95,562,415	$83,683,469	$58,843,875	9,828	149.2%

GENERAL LIABILITY INSURANCE
MUNICIPAL RELATED CLASSES*
MONOLINE AND MULTILINE COMBINED

These classes are for exposures not included in the Governmental Subdivisions classes, but that may involve municipal functions. Any private facilities rated under these classes are also included here.

POLICY YEAR ENDED	TOTAL LIMITS EARNED PREMIUM	BASIC LIMITS INCURRED LOSSES	EXCESS LIMITS INCURRED LOSSES	NUMBER OF INCURRED CLAIMS	LOSS & LOSS ADJUSTMENT EXPENSE RATIO
12/31/80	$ 2,713,060	$ 2,047,952	$ 2,138,636	308	154.3%
12/31/81	3,152,971	2,038,694	2,120,460	389	131.9%
12/31/82	3,634,554	2,946,540	612,034	545	97.9%
12/31/83	3,689,628	3,371,102	2,559,962	535	160.7%
12/31/84	3,732,128	3,958,355	2,089,123	619	162.1%
TOTAL	$16,922,341	$14,362,643	$ 9,520,215	2,396	141.1%

*Classes Included

41711	Bus Stations or Terminals
44631 44632 44633 44639	Wharf or Waterfront Property
45836	Airports
47841	Toll Bridges
47850	Drawbridges
92154	Highways or Roads or Dept. of Public Works
93131	Firehouses
91188 91231 92181 92182 92184 - 92187 93181 93182 93184 93185	Housing Projects

GENERAL LIABILITY INSURANCE
RECREATIONAL CLASSES
MONOLINE AND MULTILINE COMBINED

These classes are for recreational facilities and events such as amusement parks, grandstands, ski-lifts and fireworks demonstrations. They may be municipal or private. The 88 actual class codes are too numerous to list here.

POLICY YEAR ENDED	TOTAL LIMITS EARNED PREMIUM	BASIC LIMITS INCURRED LOSSES	EXCESS LIMITS INCURRED LOSSES	NUMBER OF INCURRED CLAIMS	LOSS & LOSS ADJUSTMENT EXPENSE RATIO
12/31/80	$ 39,270,579	$ 25,350,520	$10,003,986	5,367	90.0%
12/31/81	49,376,922	31,904,007	13,858,365	5,931	92.7%
12/31/82	56,875,885	42,194,290	16,164,611	8,448	102.6%
12/31/83	58,921,287	50,406,642	25,203,624	8,687	128.3%
12/31/84	60,226,085	55,164,373	34,009,622	8,284	148.1%
TOTAL	$264,670,758	$205,019,832	$99,240,208	36,717	115.0%

SECTION TWO
SHEET 5

GENERAL LIABILITY INSURANCE
DAY NURSERIES (CLASS 82115)
MONOLINE AND MULTILINE COMBINED

This exhibit includes experience under the OL&T Day Nurseries classification. This class is institutional day care operations, i.e., when day care is the primary function of the business. This experience does not include day care which is provided out of an individual's home and has been deemed by the underwriter to be an "incidental business exposure" according to the rules of the Homeowners Policy and is covered there.

POLICY YEAR ENDED	TOTAL LIMITS EARNED PREMIUM	BASIC LIMITS INCURRED LOSSES	EXCESS LIMITS INCURRED LOSSES	NUMBER OF INCURRED CLAIMS	LOSS & LOSS ADJUSTMENT EXPENSE RATIO
12/31/80	$ 1,785,529	$ 1,013,414	$ 268,671	254	71.8%
12/31/81	2,581,645	1,199,095	1,139,122	336	90.6%
12/31/82	3,321,139	2,026,196	1,597,703	462	109.1%
12/31/83	4,016,915	3,073,908	2,430,769	612	137.0%
12/31/84	4,586,601	4,452,400	3,331,254	840	169.8%
TOTAL	$16,291,829	$11,765,013	$8,767,519	2,504	126.0%

GENERAL LIABILITY INSURANCE
LIQUOR LIABILITY*
MONOLINE AND MULTILINE COMBINED

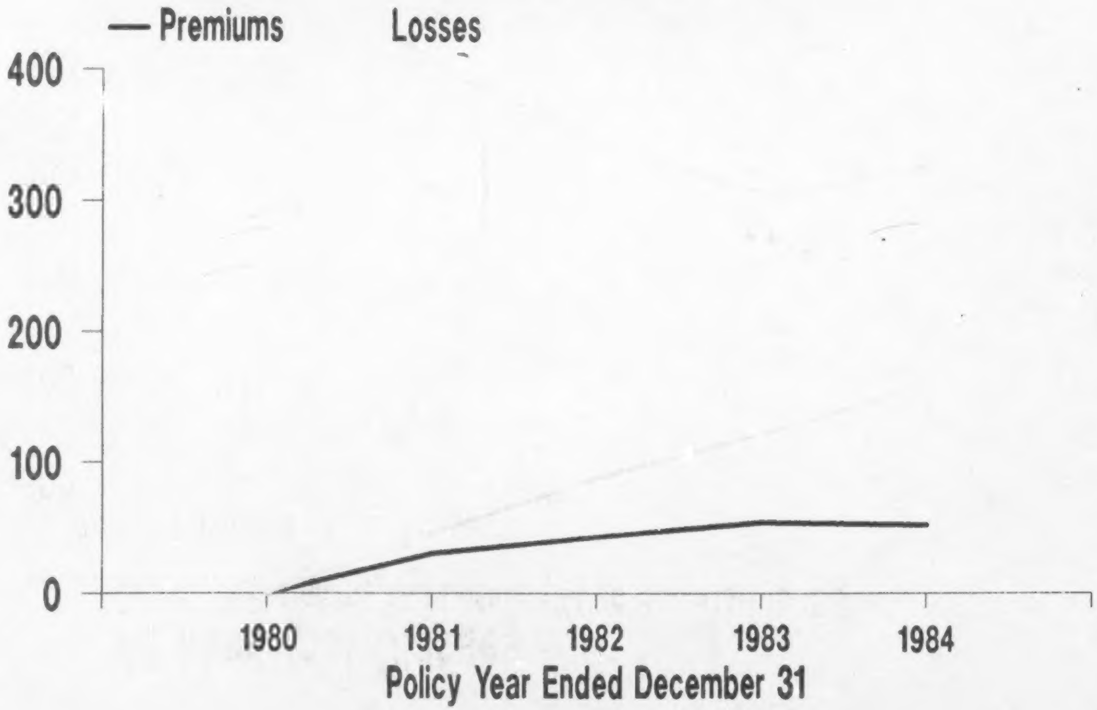
For states where liquor liability is imposed by statute or under common law principles, these classes include: clubs, package stores selling alcoholic beverages for off-premises consumption, manufacturers, wholesalers and distributors, restaurants, taverns, hotels and motels, temporary licensees, and owners or lessors of premises used by others in the business of manufacturing, distributing, selling or serving alcoholic beverages. Data from states that do not impose liquor liability by statute or under common law is also included.

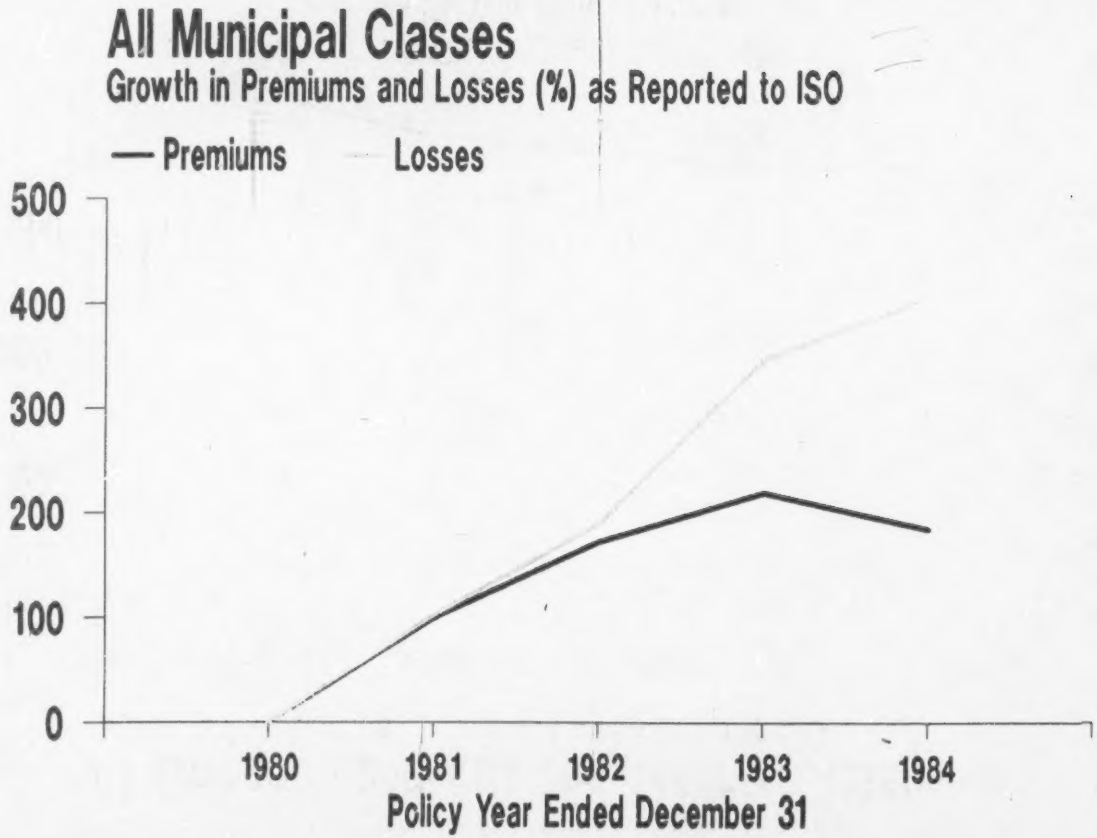
POLICY YEAR ENDED	TOTAL LIMITS EARNED PREMIUM	BASIC LIMITS INCURRED LOSSES	EXCESS LIMITS INCURRED LOSSES	NUMBER OF INCURRED CLAIMS	LOSS & LOSS ADJUSTMENT EXPENSE RATIO
12/31/80	$ 8,946,430	$ 1,917,279	$ 1,942,659	127	43.1%
12/31/81	11,595,663	3,172,391	2,690,031	195	50.6%
12/31/82	18,159,662	5,878,950	6,497,060	396	~~68.2%~~
12/31/83	14,169,075	3,526,863	4,412,736	273	56.0%
12/31/84	10,797,671	3,726,068	5,182,816	302	82.5%
TOTAL	$63,668,501	$18,221,551	$20,725,302	1,293	61.2%

* Classes Included: 50881, 50882, 58151, 58161, 58168, 58169, 58191, 58198, 58199, 50911 ,59211, 59212, 70113, 70114, 70411, 70412, 70413, 70414, 70415, 70416

All Owners, Landlords and Tenants Classes

Growth in Premiums and Losses (%) as Reported to ISO



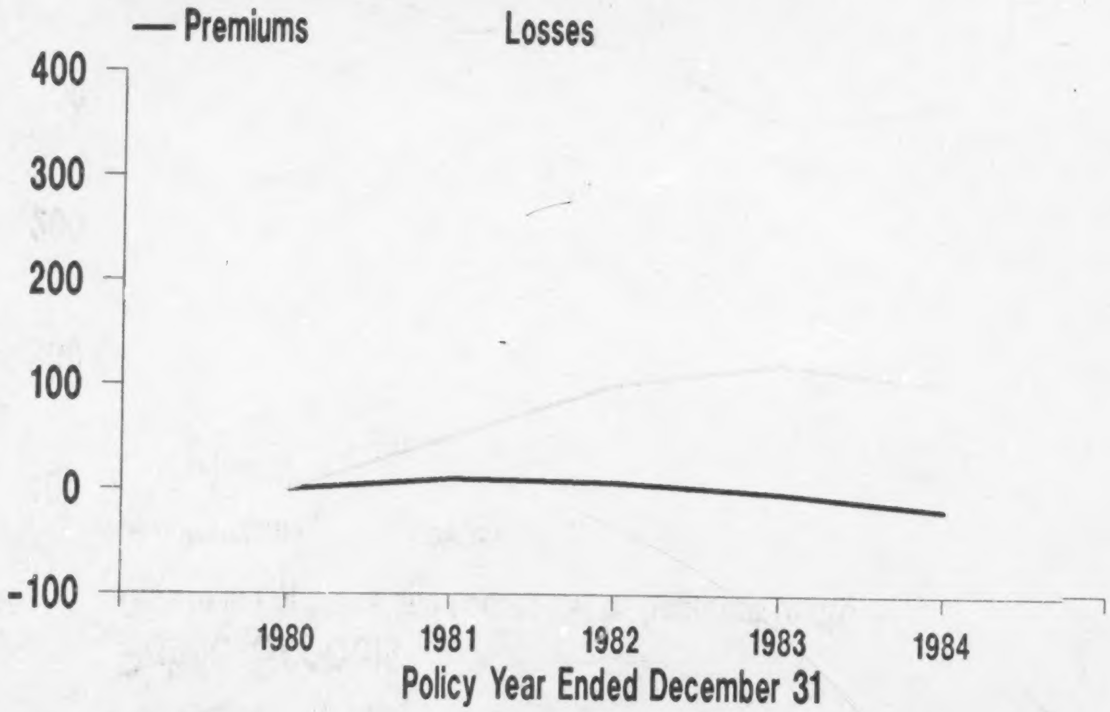


All Municipal Classes

Growth in Premiums and Losses (%) as Reported to ISO

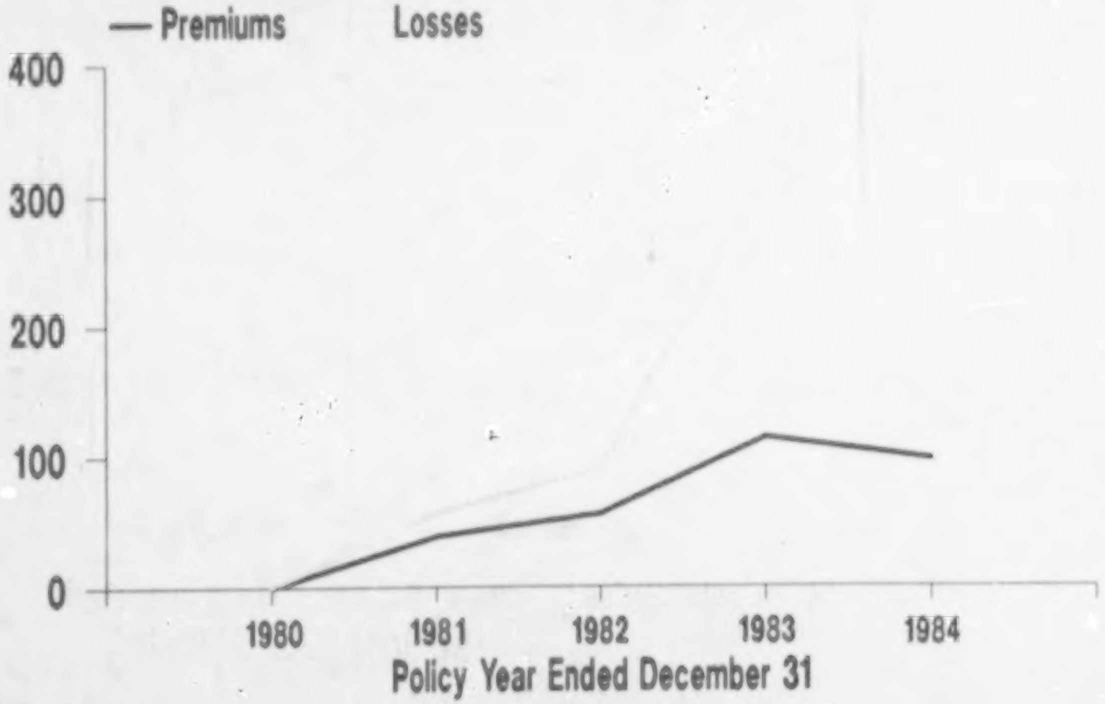
Streets and Roads

Growth in Premiums and Losses (%) as Reported to ISO



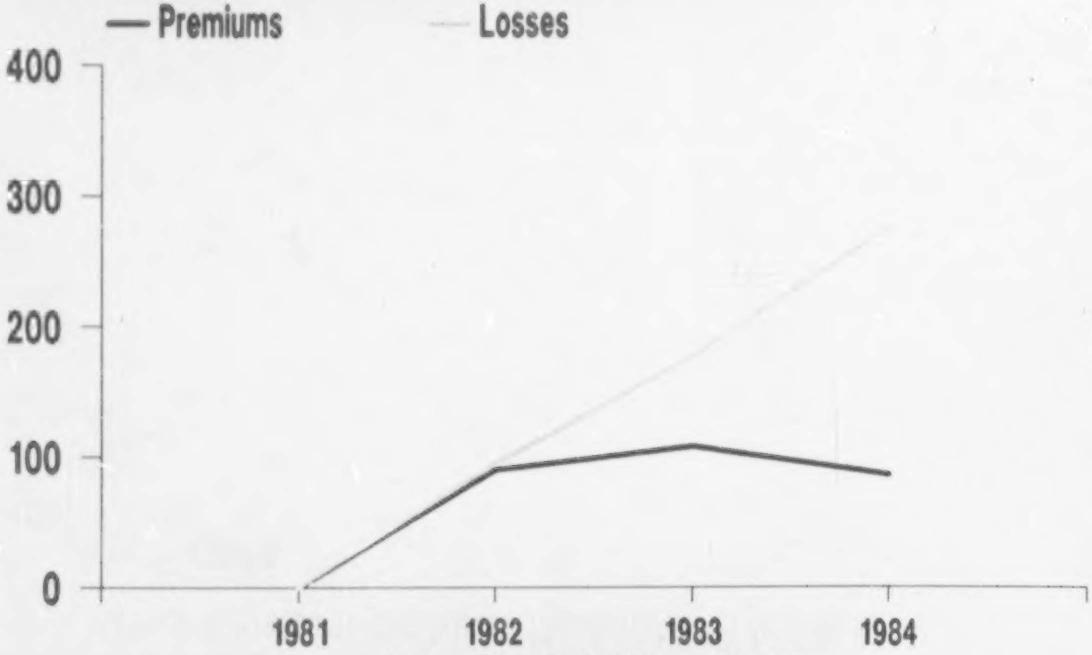
Public Schools

Growth in Premiums and Losses (%) as Reported to ISO



Governmental Subdivisions

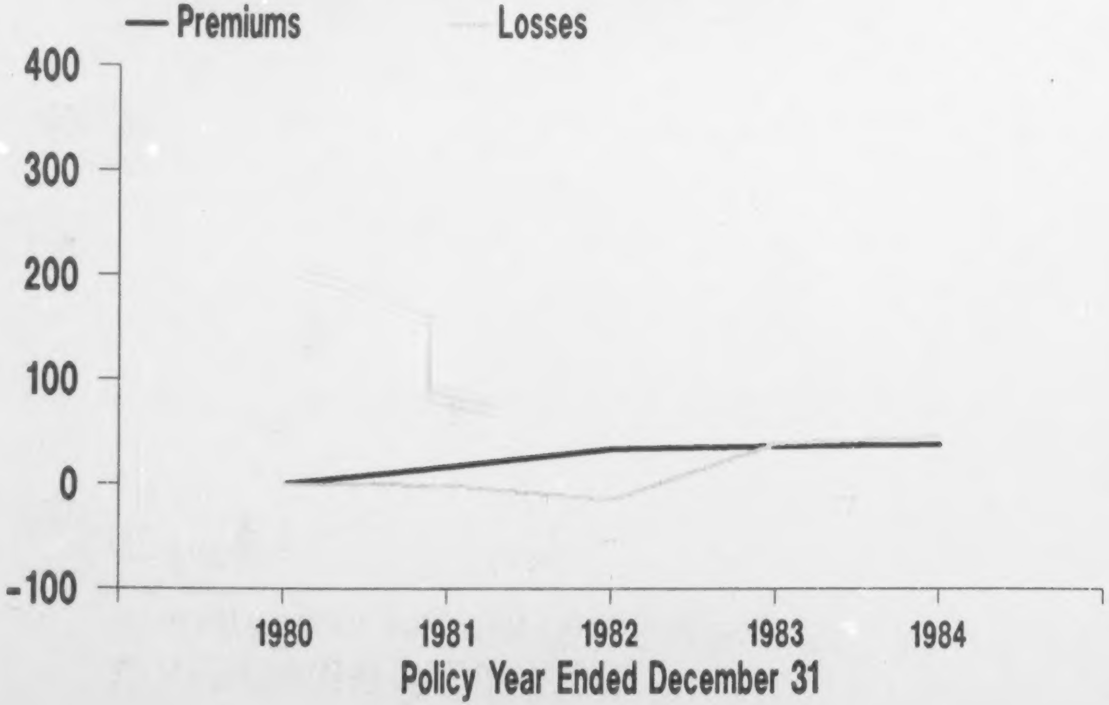
Growth in Premiums and Losses (%) as Reported to ISO



Insufficient data for policy year ended December 31, 1980.

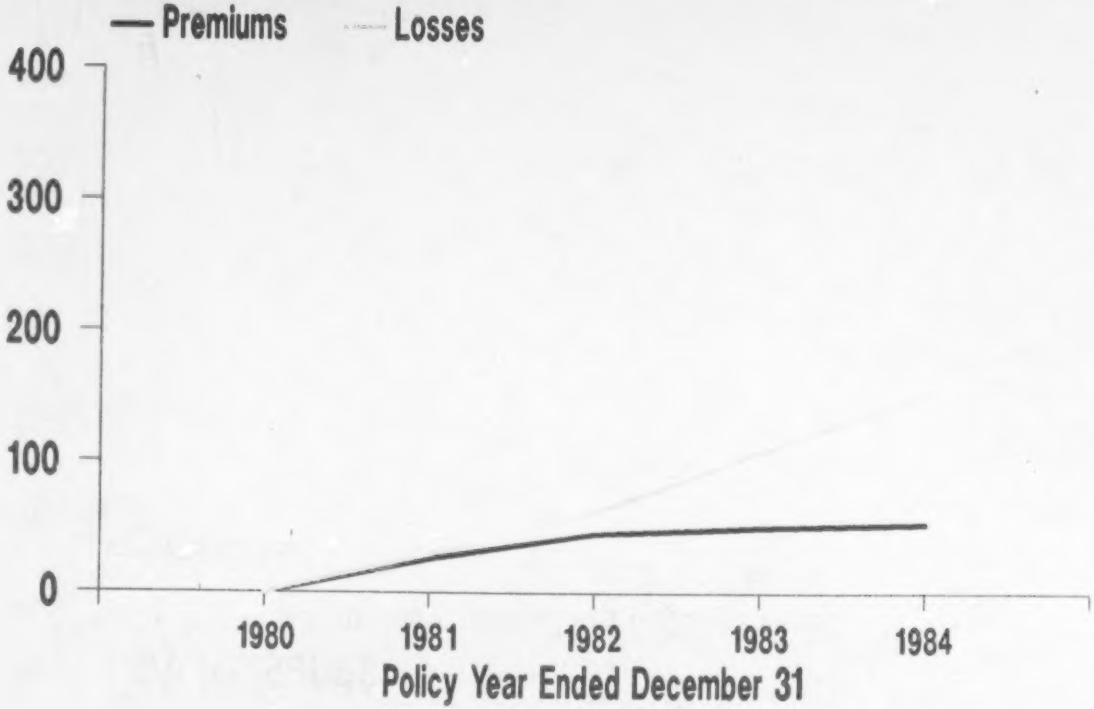
Municipal Related Classes

Growth in Premiums and Losses (%) as Reported to ISO



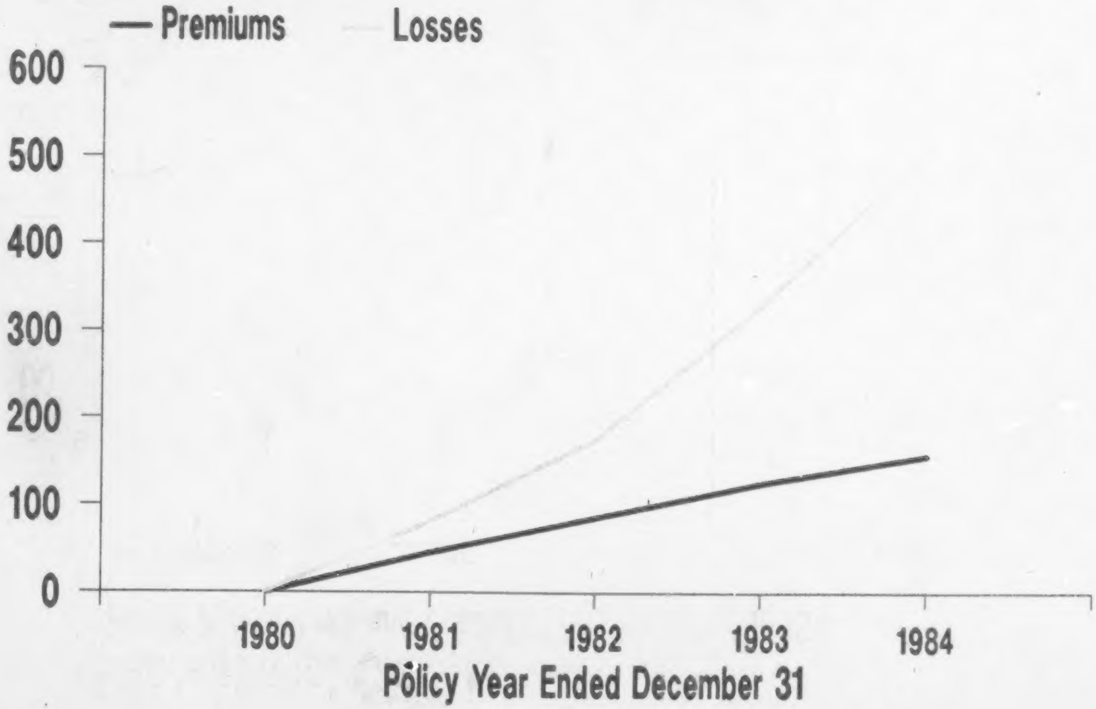
Recreational Classes

Growth in Premiums and Losses (%) as Reported to ISO



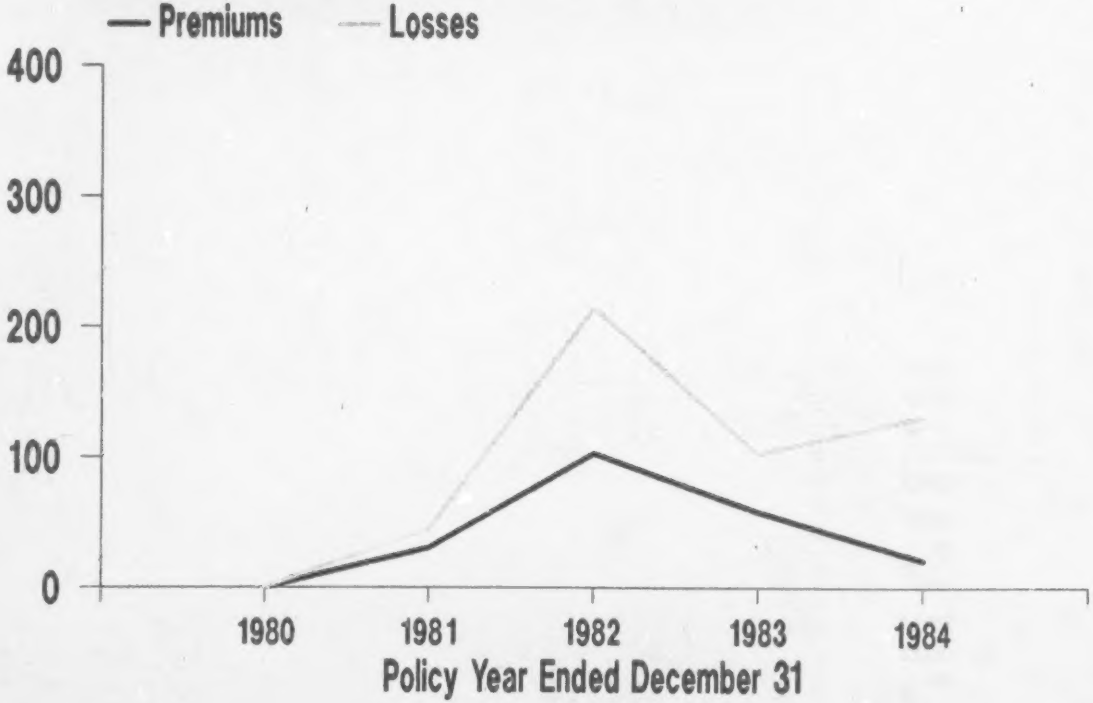
Day Nurseries

Growth in Premiums and Losses (%) as Reported to ISO



Liquor Liability

Growth in Premiums and Losses (%) as Reported to ISO



ITEM #7:

"ADVISORY RATE" PACKAGE

circular

June 13, 1985

ARKANSAS PREMISES/OPERATIONS (SUBLINE CODES 314 AND 326) BASIC LIMIT RATES TO BECOME EFFECTIVE

General Liability GL-85-139
(Rates)

ADVANCE PLANNING NOTICE

This circular is intended exclusively for ISO affiliated insurers for their information and advance planning.

LIMITED DISTRIBUTION

We have limited the distribution of the attachments to this circular. If you did not receive the attachments and wish to have the detailed information, you should contact your home office.

ISO ACTION

We:

- are revising the bodily injury basic limit rates for the Premises/Operations (Subline Codes 314 and 326) classifications of the Commercial Lines Manual.
- will file this revision on July 12, 1985.

RATE CHANGE

The effect of this revision is +6.9%.

AUTOMATED SYSTEMS IMPACT

Refer to:

- circular GL-83-137(3-23-83) for information needed to update and maintain ISO rates for Premises/Operations coverage in machine readable format.
- page 1 for revised bodily injury base class rates.

Caution:

The rates you develop should agree with the basic limit rates contained in this circular (pages 2-4). If not, check your capping and rounding procedures.

EFFECTIVE DATE

These changes are applicable to all policies written on or after August 1, 1985.

Insurance Services Office, Inc., 160 Water Street, New York, New York 10038 (212) 487-5000

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COMPANY ACTION

If you have authorized us to file on your behalf and decide:

- to use these rates and the effective date, you are not required to file anything with the Arkansas Insurance Department.
- to use these rates but not the effective date, you should notify the Arkansas Insurance Department prior to our effective date, but not before July 12, 1985.
- not to use these rates you should notify the Arkansas Insurance Department prior to our effective date but not before July 12, 1985.
- to deviate from these rates you should notify the Arkansas Insurance Department.

In all correspondence with the Arkansas Insurance Department on this filing you should refer to our filing designation number GL 85 BOLT1.

ATTACHMENTS

- Revised Bodily Injury Base Class Rates(page 1)
- Revised Bodily Injury Basic Limit Rates(pages 2-4)

Easter A. Courtney

Easter A. Courtney
Commercial Casualty Division

STATE: Arkansas
OWNERS, LANDLORDS & TENANTS
PREMISES AND OPERATIONS
(Subline Codes 314 & 326)

% Change + 6.9

Class Group	Revised Bodily Injury Base Class Rate
1	2.399
2	2.547
3	4.628
4	13.683
5	29.624
6	17.957
7	4.410
8	.832
9	7.703
10	1.535
11	.645
12	12.212
13	72.117

* Revised rates are limited at -19.8% / +50.0%
# Revised Storekeeper rates (Class Group 12) are at least 25% above the combined BI and PD rates for corresponding Premises and Operations (Subline Code 314) classification.
& The 25% differentials (#) overrules the (*) limitation.

Use 1982 Countrywide Class Differentials.
General Liability Circular GL-83-137 (March 23, 1983)

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ARKANSAS TERRITORY 01

OWNERS, LANDLORDS AND TENANTS BODILY INJURY LIABILITY INSURANCE

AREA, FRONTAGE, SCHOOLS, THEATRES AND CERTAIN MISCELLANEOUS CLASSIFICATIONS

PRESENT AND REVISED INDUSTRY CLASSIFICATION RATES

I.C. CODE	PRESENT RATE	REVISED RATE	I.C. CODE	PRESENT RATE	REVISED RATE	I.C. CODE	PRESENT RATE	REVISED RATE	I.C. CODE	PRESENT RATE	REVISED RATE
07290	1.300	1.600	53981	.180	.190	59181	13.000	14.500	65150	.032	.033
18120	.280	.290	53989	1.900	2.000	59215	4.600	4.600	65180	.100	.100
18180	.160	.170	53991	2.400	2.400	59320	3.700	3.700	65198	.810	.830
39998	.280	.290	54111	12.500	13.500	59341	2.200	2.200	65310	36.500	37.500
39999	.150	.150	54121	26.000	29.500	59365	3.700	3.700	65501	2.200	2.200
41122	.610	.620	54131	12.500	13.500	59503	3.700	3.700	70112	56.000	72.000
41191	7.500	8.400	54211	12.500	13.500	59711	3.300	3.300	70113	22.500	29.000
42230	.140	.140	54411	3.700	3.700	59901	4.600	4.600	70115	.810	.830
44632	1.100	1.100	54431	13.500	15.000	59911	.590	.660	70119	8.400	11.000
44633	4.900	5.000	54511	3.700	3.700	59921	9.100	9.300	70131	.560	.720
44639	.450	.460	54521	13.500	15.000	59951	3.300	3.300	70122	.560	.720
44697	4.900	5.500	54601	6.400	6.500	59961	.730	.740	70310	.370	.370
47041	.110	.110	55419	.100	.100	59981	5.500	5.600	70312	.370	.370
47891	12.000	13.000	55971	2.400	2.400	59991	3.700	3.700	70321	5.900	4.700 *
47893	7.300	8.200	56991	4.600	4.600	59993	.650	.670	70322	13.000	10.500 *
47894	39.500	44.000	57121	1.300	1.300	59997	3.700	3.700	70324	197.000	221.000
49521	4.900	5.000	57225	3.700	3.700	59998	1.300	1.300	70411	3.900	4.400
50341	.730	.740	58121	.400	.440	60200	3.800	3.400	70701	.810	.830
50421	2.700	2.800	58131	6.400	6.500	60400	1.400	1.300	70702	.280	.290
50531	.730	.740	58161	16.000	18.000	64112	2.800	2.500	70703	1.900	2.000
50711	.730	.740	58162	.810	.830	65101	58.500	57.500	72102	1.500	1.500
50712	.730	.740	58250	16.000	18.000	65102	58.500	57.500	72103	.041	.042
50811	.730	.740	58251	16.000	18.000	65121	2.800	2.500	72104	.370	.370
50991	.730	.740	58252	16.000	18.000	65131	2.400	2.400	72106	.270	.280
52511	2.200	2.200	58253	16.000	18.000	65132	2.400	2.400	72210	3.700	3.700
53111	16.000	18.000	58254	16.000	18.000	65133	2.800	2.800	72310	3.500	3.500
53201	.650	.670	58255	16.000	18.000	65134	1.500	1.400	72410	1.800	1.900
53311	15.000	16.500	58256	16.000	18.000	65140	1.500	1.400	72510	3.700	3.700
53411	.590	.660	59121	3.700	3.700	65143	12.000	12.000	72711	1.500	1.500
53511	11.000	11.000	59131	3.700	3.700	65147	24.500	24.000	72712	3.700	3.700

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ARKANSAS TERRITORY 81

OWNERS, LANDLORDS AND TENANTS BODILY INJURY LIABILITY INSURANCE

AREA, FRONTAGE, SCHOOLS, THEATRES AND CERTAIN MISCELLANEOUS CLASSIFICATIONS

PRESENT AND REVISED INDUSTRY CLASSIFICATION RATES

I.C. CODE	PRESENT RATE	REVISED RATE	I.C. CODE	PRESENT RATE	REVISED RATE	I.C. CODE	PRESENT RATE	REVISED RATE	I.C. CODE	PRESENT RATE	REVISED RATE
72992	.590	.660	79417	4.900	5.500	79493	3.900	4.400	82210	.720	.920
72997	111.000	123.000	79420	.400	.440	79495	2.100	2.600	82211	.280	.290
73124	36.500	37.500	79422	.990	1.100	79496	16.000	17.500	82310	1.400	1.800
73199	5.900	6.600	79424	.990	1.100	79497	.990	1.100	82420	1.000	1.500
73310	.420	.380	79425	12.000	13.000	80111	2.100	1.900	82993	.720	.920
73930	.160	.180	79428	3.200	3.500	80410	2.100	1.900	82994	.720	.920
75230	.690	.710	79431	.390	.400	80611	7.600	7.700	82998	2.200	2.000
75234	.370	.370	79433	12.000	13.000	80613	2.800	2.500	86311	2.800	2.500
75235	.570	.580	79434	107.000	119.000	80711	2.100	1.900	86411	3.000	3.300
75252	.810	.830	79435	2.100	2.600	80921	3.400	3.500	86412	1.400	1.500
77000	79.000	88.000	79436	.390	.400	80924	10.000	10.500	86413	.080	.090
78320	.520	.650	79451	5.900	6.600	80925	3.800	3.900	86415	.120	.130
78321	.930	1.200	79452	9.900	11.000	80927	19.000	21.000	86416	.080	.090
78329	.810	.830	79461	78.000	87.000	80991	2.300	2.300	866[illegible]	.420	.540
78330	.440	.550	79462	.550	.600	80992	2.100	1.900	86612	1.200	1.500
78331	.160	.190	79464	1.300	1.600	80993	2.100	1.900	86711	1.400	1.800
79112	1.800	2.000	79465	1.300	1.600	80994	2.100	1.900	89310	.970	.890
79300	4.300	4.900	79466	1.300	1.600	80995	2.100	1.900	93120	4.700	5.000
79410	12.000	13.000	79467	1.300	1.600	80996	19.000	21.000	93131	.810	.830
79411	1.100	1.400	79468	.780	.970	80997	4.200	4.200	93190	2.300	2.300
79412	1.200	1.500	79472	6.700	7.500	82111	.350	.530 *	93221	.680	.920
79413	2.300	2.900	79482	4.200	5.200	82113	.840	1.100			
79414	.520	.650	79483	4.700	5.800	82115	3.600	4.600			
79416	4.900	5.500	79492	.990	1.100	82116	1.800	2.300			

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INSURANCE
SERVICES OFFICE

ARKANSAS

STOREKEEPER'S LIABILITY INSURANCE

PRESENT AND REVISED INDUSTRY CLASSIFICATION RATES

TERRITORY 01

I.C. CODE	PRESENT RATE	REVISED RATE
52511	7.200	6.700
54111	21.000	19.500
54131	16.000	17.000 &
54211	17.000	17.000 @
54411	11.000	10.500
54431	17.000	19.000 &
54511	19.500	18.500
54521	23.000	21.500
54601	14.500	13.500
56991	6.600	6.100
57121	3.300	3.100
58131	23.000	21.500
58132	23.000	21.500
59215	7.200	6.700
59320	7.200	6.700
59341	3.300	3.100
59711	4.600	4.300
59901	7.200	6.700
59961	7.200	6.700
59991	7.200	6.700
59997	7.200	6.700
59998	3.300	3.100
72210	7.200	6.700
72510	7.200	6.700
72712	7.200	6.700

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ITEM #8:
CLOSED-CLAIM INFORMATION

PROPERTY/CASUALTY INSURANCE INDUSTRY

CLOSED CLAIM STUDIES

1) Product Liability Closed Claim Survey: A Technical Analysis of Survey Results, Insurance Services Office, 1977.

2) Report of the All-Industry Committee Special Malpractice Review: 1974 Closed Claim Survey (Technical Analysis of Survey Results), 1976.

3) Automobile Injuries and their Compensation in the United States Vol I and Vol 2, All-Industry Research Advisory Committee, 1979.

4) Report of American Insurance Association's Special Committee to Study and Evaluate Keeton-O'Connell Basic Protection Plan and Automobile Accident Reparations, 1968.

ITEM #9:

ISO PRODUCT-LIABILITY CLOSED CLAIM SURVEY

Introduction

Background

Concern about product liability developed in the business community and government when members of the business community, particularly manufacturers, experienced substantial increases in the cost of their product liability insurance and, also, when some had difficulty in obtaining desired product liability coverage.

While market problems have been alleviated where state regulators have brought buyer and seller together by implementing Market Assistance Programs, the federal government is still involved in the product liability issue. Under the lead of the Department of Commercie, a Federal Interagency Task Force studied all aspects of the problem and will recommend possible remedies. Three consultant reports were released by the Department of Commerce early in 1977 and a final Task Force Report is expected in late October or early November of 1977.

These price and market apprehensions were heightened by the sparsity of data relevant to product liability tort law and its underlying social climate. The most pressing need today is for information concerning causes of product liability claims, the types of products involved, the place of occurrence—whether at home or at work—as well as for other quantifiable facts which are required in order to put things in proper perspective.

Insurance Services Office (ISO) is an insurance industry statistical and rating organization which compiles data for product liability insurance. Although it has statistics which are used for product liability rate making purposes, those data are not specific enough to answer the types of questions currently being asked.

Objectives of the ISO Survey

These emerging developments in product liability were recognized by Insurance Services Office in early 1976 and, in order to obtain the needed information, ISO initiated the Product Liability and Completed Operations Closed Claim Survey.

This definitive study is now complete. Twenty-three major property-liability insurers, representing most of the product liability insurance business written in the United States, participated in the survey which contains the most extensive data base of product liability claims information ever compiled.

This industrywide survey was designed to provide the kinds of detailed information necessary to make a quantitative analysis of the causes of the problem, and to provide insight for action which might be taken to alleviate the situation.

The compilation of this comprehensive base of product liability claim data will be useful in evaluating various legislative alternatives to the present tort liability reparations system. Also, for those who have been seeking to alleviate the complex problems arising from the product liability issue, there is now a definitive reference document to help formulate answers to the most commonly asked questions and to lend assistance in determining the effectiveness of possible remedies.

Scope of the Study

The twenty-three participating insurers submitted a total of 24,452 survey forms covering all their product liability claims which were closed between July 1, 1976 and March 15, 1977. The final report generated from this information consists of discussion and presentation of 39 summary compilations, plus 276 statistical exhibits and 117 tables to assist the reviewer in interpreting the results. The complete technical presentation and analysis (about 500 pages) is available for those interested in reviewing the findings in depth and those wishing to pursue further analyses (see page 9 for details).

The following pages present highlights of the survey.

Major Findings

Types and Amounts of Claims

An injured party may bring a claim against an insured if he thinks the insured's product was responsible for either bodily injury (BI) or damage to his property (PD), or perhaps both. Of the total number of claims paid, about 61% involve only bodily injury, 37% only property damage, and 2% involve both. However, of the total dollars paid for all claims, bodily injury incidents account for a larger proportion, 83%, of the total.

Table 1

TYPE OF PAID CLAIMS

	% of Paid Claims	% of Claim Payments
BI only	60.6%	83.0%
PD only	37.0	13.4
Both BI and PD	2.4	3.6
Total	100.0%	100.0%

Although the large majority of payments are relatively small (more than 2/3 are under $1,000), the bulk of the overall payment amount is spent in the few larger cases. Fewer than 1% of the bodily injury paid claims are responsible for more than 50% of the total BI payment dollars. Similarly, for property damage, fewer than 1% of the paid claims account for more than 45% of the total PD payment dollars.

A product liability incident involving a single injured party may result in claims against more than one defendant. As might be expected, the average payment calculated on a per incident basis turns out to be higher than the average payment on a per claim basis. Average payments for both bodily injury and property damage are shown in the following table.

Table 2

AVERAGE PAYMENTS

	Per Claim	Per Incident
Bodily Injury	$13,911	$26,004
Property Damage	3,798	6,871

The claim payments analyzed in this survey include both those in which insurance payments were made and those in which no payment was made. The total amounts paid to claimants, whether through settlement or through award, were considered. Not all of this amount was covered by insurance because some awards exceeded the limits of the insurance policy. In some cases coverage for the particular incident may not have been included in the policy, and some insureds have policies involving deductibles. The survey results show that about 97% of the total bodily injury payments and 89% of the total property damage payments were covered by insurance.

Additional Costs

In addition to paying claims on behalf of the insured, the insurance company bears the expense of investigating the claim and all defense costs associated with the case. Typically these costs include defense attorney and expert witness fees, travel expenses and other items directly related to the particular claim. For product liability claims these costs are considerable.

For every dollar paid for claims, insurers incur in defense costs an additional 35¢ (BI) and 48¢ (PD), no matter who wins the case. By far the largest item contributing to the cost of settling claims is defense attorneys' fees, which account for about 83% of the defense costs.

The average amount of expense per bodily injury claim is about $3,500 regardless of how the claim is settled. However, this ranges significantly from about $25 for cases in which no suit is filed, to an average of almost $25,000 for cases which go all the way to a court verdict.

The Time Factor

The average length of time between the occurrence of a product liability incident and an initial report to the defendant or his insurer is relatively short. Within 12 months of the occurrence, about 86% of bodily injury and 90% of property damage claims have been reported. These claims ultimately involve 52% of the total payment dollars in bodily injury cases, 75% in property damage cases.

The time from the first report until closing of the claim file, however, is typically much longer. Four years after the first report, claims involving 36% of the ultimate bodily injury payment dollars and 33% of the total property damage payment dollars still have not been closed.

The time a product may be in use before any incident occurs may be quite long. Some 4% of the bodily injury claims, involving 10% of ultimate payment dollars, still have not occurred 8 years after the date of manufacture of the product. Where capital goods are involved, the average time lapse from manufacture to occurrence is more than 3 years longer than the overall average.

Payments Compared With Economic Loss

One section of the Report compares payments received by product liability claimants with the claimants' actual economic loss. Economic loss for bodily injury claims includes such out-of-pocket expenses as medical bills, housekeeping expenses and rehabilitation costs, as well as lost wages. For property damage claims, economic loss includes the cost of the direct physical damage to the claimant's property, the expenses resulting from the loss of use of that property, or from recall of products.

In most instances, a portion of the award or settlement paid to the injured party goes to his attorney under a prearranged agreement. Thus, it is entirely possible that where the final claim payment exceeds the actual amount of economic loss, in some cases it may still be insufficient to reimburse the claimant's expenses and lost wages because of his legal fee commitments.

Several factors may cause the product liability claim payment to be either higher or lower than economic loss. For example:

- Under the laws of some states, the principle of comparative negligence limits payment to a portion of economic loss. This occurs if it is determined that the claimant's own negligence contributed to the accident.

- Cases where the evidence is not clear-cut may end in a compromise settlement out of court.

- In some cases involving more than one defendant, one or more defendants may be sued on some basis other than product liability. For instance, a manufacturer of medical equipment may be sued under product liability, while a surgeon involved in the same case may be sued under professional liability. Product liability would represent only a portion of the total settlement in such cases.

- Policy limits, if known by the claimant or his attorney, may in some cases influence the payment amount.

- Punitive damages may be awarded over and above economic loss.

- Payments for pain and suffering may be awarded over and above economic loss.

In this connection the survey shows that:

- For bodily injury, payments tend to be greater than economic loss.

- The tendency of payment to exceed economic loss is stronger for the lower amounts of economic loss, and diminishes as the level of economic loss rises. For cases involving a great amount of economic loss (more than $500,000), the product liability payment tends to be less than economic loss.

- Ten per cent of all paid claims in bodily injury cases are for more than 10 times the economic loss; 50% are at least twice the economic loss. On the other hand, 5% of all claimants who are ultimately paid something receive 50% or less of their economic loss. As noted, there may be sources of payment other than product liability in some of these cases.

- On the average, the economic loss experienced by those who receive payments for bodily injury claims is made up of 23% medical costs, 72% lost wages and 5% miscellaneous expenses such as housekeeping and rehabilitation costs. These proportions vary, with medical expenses predominating at lower levels of economic loss and wages at the higher levels.

- More than 50% of the claims for property damage are equal to the economic loss. A large portion of the remaining claim payments tend to be below economic loss as there is seldom reason, such as is common in bodily injury cases, for payments above the economic loss.

Workers' Compensation

Workers injured on the job are involved in 11% of product liability incidents resulting in claim payments. However, these incidents account for 42% of total bodily injury payments. That is explained by the fact that the average payment of $97,884 for these incidents is much higher than the overall average. It should be emphasized that the $97,884 represents product liability claim payments only.

An injured worker may collect Workers' Compensation Benefits and still collect under product liability from a third party. A worker injured on the job would routinely receive payment from his employer or the employer's insurance carrier under the Workers' Compensation Law. In most states, a legal "sole remedy rule" bars the worker from suing the employer for any further amounts.

However, if a defective machine or other product is believed to have caused the injury, the injured employee may have a cause of action against the manufacturer or seller of that product. In turn, the employer may have a cause of action against the manufacturer or seller to recover amounts he has already paid the worker under Workers' Compensation. As a further complication, the sole remedy rule operates to prevent the manufacturer or seller from countersuing the employer even if the employer's negligence is believed to have caused or contributed to the injury.

The survey discloses that about 24% of the total dollar amount paid for all bodily injury claims was paid in cases involving possible employer negligence. In most of these cases, recovery or some contribution to the payment would have been sought from the employers by the product liability insurers if such recovery were not prevented by the sole remedy rule.

Taking a different perspective, claims involving 13% of the total bodily injury payments are reported to have been instigated by employers in order to recover payments made under Workers' Compensation.

Who Is Liable Under Product Liability

Almost any business may be liable for a product liability incident. Practically no one in the stream of commerce is immune from suit. However, some businesses are more frequent targets than others.

Manufacturers account for 87% of the total amount paid for product liability claims.

Food products account for 56% of all paid product liability claims. However, since food claims tend to be small, they represent only 2% of total bodily injury payment dollars.

Grounds for Claims

The legal basis for the claim or suit is breach of warranty in slightly more than 1/3 of both the bodily injury and property damage incidents. The remainder of the bodily injury cases are based, in about equal numbers, on negligency and on strict liability (defect without negligence) while about 48% of property damage cases are based on negligence. It appears to be easier for a plaintiff to win a case based on strict liability than on negligence, because negligence does not have to be established under the doctrine of strict liability. It is sufficient that the product was defective and the defect caused the injury.

How Claims Are Settled

Approximately 73% of the bodily injury claims and 83% of the property damage claims are settled without the filing of a lawsuit. These cases, not surprisingly, account for only a small portion of the total payments made (7% for bodily injury and 33% for property damage).

Fewer than 4% of all claims go all the way to a court verdict, and in those cases, fewer than 25% of defendants are found liable.

Using the Survey Findings

The data collected and analyzed in the ISO Closed Claim Survey provide a firm statistical base which can and will be used in evaluating various legislative alternatives to the current tort liability reparations system. However, caution is recommended and the reviewer should clearly understand what a closed claim survey can and cannot do.

A closed claim survey, by definition, reveals nothing about adequacy or inadequacy of insurance rates, or profits or losses of insurers. The survey was not designed nor intended to gather this type of information and no premium or rate information was requested. Consequently, no conclusions should be drawn nor inferences made from the survey regarding these aspects.

What the closed claim survey does is to give very detailed information, obtained from careful review of insurer claim files, about the nature and extent of actual claims which were closed during the specified time period. Previously, such detailed information was not available because it is not the type of information routinely gathered for standard actuarial determinations.

Another inherent characteristic of a closed claim survey should be noted by reviewers who will do analyses beyond those presented in the Final Report. The information submitted by the participating insurers presents data on claims closed during an 8½ month period in 1976-77. But, many of the incidents upon which those claims were based occurred years ago, some more than 10 years ago. Because these incidents took place at various times over many years, conclusions or comparisons could be misleading because the value of the claim settlements or economic loss items reflects the value of the dollar in those various time periods.

For this reason the data were adjusted by recognized actuarial techniques to a common cost level. The procedures used to adjust the data to a common cost level are explained fully in the Technical Analysis. The report also contains all of the statistical exhibits in both adjusted and unadjusted forms. It should be noted that the findings as presented in these highlights, as well as in the Final Report, are drawn from the adjusted data base.

Conclusion

The Final Report of the ISO Product Liability Closed Claim Survey is a valuable reference document that undoubtedly will be read and studied by many. It offers a great deal of statistical information, not available from any other source, which should be extremely helpful to those wishing to pursue additional study of this complex subject.

Companies Participating in the ISO Product Liability Closed Claim Survey

Aetna Casualty and Surety Company
Aetna Insurance Company
Chubb & Son Inc.
Commercial Union Insurance Company
Continental Insurance Company
Continental Casualty Company
Crum & Forster Insurance Group
Employers of Wausau
Fireman's Fund Insurance Company
Hartford Insurance Group
Home Insurance Company
Insurance Company of North America
Liberty Mutual Insurance Company
Lumbermens Mutual Casualty Company
Maryland Casualty Company
Pennsylvania Manufacturers' Association Ins. Co.
Reliance Insurance Company
Royal Globe Insurance Company
SAFECO Insurance Company of America
Sentry Insurance Company
St. Paul Fire and Marine Insurance Company
Travelers Insurance Company
United States Fidelity and Guaranty

Availability of Reports

Copies of the complete Final Report-Technical Analysis may be obtained by sending $10 for each copy requested to: Accounting Division, Insurance Services Office, Two World Trade Center, 19th Floor, New York, New York 10048. Additional copies of this "Highlights" document are available free from the ISO Product Distribution Division, 160 Water Street, New York, New York 10038.

ITEM #11:

DAY CARE CENTERS
PREMIUM AND LOSS INFORMATION

GENERAL LIABILITY INSURANCE
DAY NURSERIES (CLASS 82115)
MONOLINE AND MULTILINE COMBINED

This exhibit includes experience under the OL&T Day Nurseries classification. This class is institutional day care operations, i.e., when day care is the primary function of the business. This experience does not include day care which is provided out of an individual's home and has been deemed by the underwriter to be an "incidental business exposure" according to the rules of the Homeowners Policy and is covered there.

POLICY YEAR ENDED	TOTAL LIMITS EARNED PREMIUM	BASIC LIMITS INCURRED LOSSES	EXCESS LIMITS INCURRED LOSSES	NUMBER OF INCURRED CLAIMS	LOSS & LOSS ADJUSTMENT EXPENSE RATIO
12/31/80	$ 1,785,529	$ 1,013,414	$ 268,671	254	71.8%
12/31/81	2,581,645	1,199,095	1,139,122	336	90.6%
12/31/82	3,321,139	2,026,196	1,597,703	462	109.1%
12/31/83	4,016,915	3,073,908	2,430,769	612	137.0%
12/31/84	4,586,601	4,452,400	3,331,254	840	169.8%
TOTAL	$16,291,829	$11,765,013	$8,767,519	2,504	126.0%

Chairman **Pickle**. Let me ask you first, did you have any comment or questions to ask, Mr. Thomas? I want to go to the next hearing as soon as possible. Mr. Thomas.

Mr. **Thomas**. Thank you, Mr. Chairman. I want Ms. Walters to finish your question. Ms. Walters, you said a number of factors converged. One was the high interest rate to invest money to make money, and that the reinsurance market attracted a great deal of money from businesses that were not sophisticated in terms of understanding what the business was all about. Do you have any key factors you want to add to that?

Ms. **Walters**. The problem is as reinsurers lowered prices to primary companies, primary companies then had the ability further to lower prices to consumers in the marketplace. At the same time that this was happening, we were seeing court interpretation of insurance contracts, in 1979, 1980, and 1981, where the Jackson Township is the most well-known case, where the court negated the insurance contractual language, we thought we had excluded coverage and said, "No, no, you are going to pay for those kinds of things which you thought were excluded."

The finding of retroactive liability was one of the explanations that drove up general liability losses at three times the rate of growth of GNP. What happened was, I believe those high interest rates obscured, because investment income was healthy, obscured what was happening with the underlying loss pattern and loss growth. All of that happened at the same time and kept driving prices ever lower.

I do not believe insurance company managements were making management decisions that they wanted to achieve operating losses. They all were expecting operating profits. This cash-flow underwriting that has been characterized is not a new strategy. It is, in fact, the way the property casualty industry has existed for at least the last 30 years. In a competitive industry, you must consider all sources of income in making your pricing decisions; you can't hide it. If you try to hide it, a competitor will come in and sell at a lower price and still achieve a decent operating profit.

All this happened at the same time. When operating results started turning negative, that is when insurers said "I don't care about market share, it is like trying to make up on volume when you are losing 3 cents on every dollar. Market share doesn't improve that.

They started realizing in late 1984, 1985, they had to get sanity back into pricing, started firming prices, underwriting on a sounder basis and moving prices back up in line with loss costs, and we now have a new commercial general liability policy form which I believe will help.

Mr. **Thomas**. So, in terms of the attempt to analyze a particular period in history, it is clear that there were some unprecedented occurrences; but also that there were management decisions that were made that resulted in exaggeration and intensifying of the downward cycle?

Ms. **Walters**. That is correct.

Mr. **Thomas**. And only one of the points that you mentioned had to do with really outside factors, the court interpretation of contracts.

Would you put any assessment of weight on any of those three that you outlined? How much was management decisions that were more opportunistic than they were sound in the long run versus courts changing the pattern of retroactive liability, et cetera?

Ms. WALTERS. That is another question that one has to deal with almost on a line-by-line basis. For example, anything dealing with pollution or environmental liability, clearly I would say all of the problems in that area are the result of the legal environment, not insurer pricing or underwriting.

On the other hand, something like day care problems can be resolved, by and large, by the private sector, and are being resolved by the private sector. But you cannot give away coverage at an inadequate price. Insurers have to charge a price sufficient to cover losses. So they may represent in one sense the specter of where the legal environment has played havoc and where something is manageable in the private sector.

Municipality problems, I think, are more in the area of legal——

Mr. THOMAS. In the oil industry, it was felt proper public policy to indicate that when profits were too high, you had a windfall profits tax.

Now, apparently, when the prices go too low, it is acceptable to allow them to suffer all the losses on the low side. But they can't suffer the benefits on the high side. If there was an examination of bracketing, my assumption is that you would prefer top and bottom bracketing. I don't think you would prefer a model along the windfall profits tax model in the oil industry.

I am asking you to talk to me about bracketing and what seems to be more acceptable to you.

Ms. WALTERS. Mr. Thomas, if, by bracketing, you mean limiting increases as well as decreases——

Mr. THOMAS. Yes.

Ms. WALTERS [continuing]. I think in response to a question that came before, I said that one way to limit the effect of cycles is to reimpose cartel-type pricing. I don't know who makes that decision. Clearly, it has got to be a legislative-type decision. But it seems that all economic studies and the whole thrust of the American economy today is to go more toward deregulation and less toward imposing——

Mr. THOMAS. Apologies if that question has been asked. I am bouncing between two subcommittees. I will check the record.

Thank you very much, Mr. Chairman.

Chairman PICKLE. Mr. Gibbons.

Mr. GIBBONS. A very brief question.

During all this time that these companies were going broke and their stock price was going up, did these same companies pay any bonuses or salary increases to their top executive people?

Ms. WALTERS. I have no idea, Mr. Gibbons.

Mr. GIBBONS. Who collects those data?

Ms. WALTERS. I think you have to look at that on a State-by-State, company-by-company level.

Mr. GIBBONS. Don't you collect those data?

Ms. WALTERS. No, sir, not on company managements and prices, salaries they pay their people, not in any way.

I think the facts would show, though, stock prices probably didn't continue to go up on the 40 companies that went insolvent.

Mr. **Gibbons**. Well, do you have any personal knowledge of any of these people?

Ms. **Walters**. No, sir, I do not.

Mr. **Gibbons**. You just close your eyes on that?

Ms. **Walters**. No, sir.

Mr. **Gibbons**. No trade publications show anything?

Ms. **Walters**. For property/casualty insurance companies, of which I have some passing knowledge—but, believe me, I have no idea what the company managements are paid or anything that relates to that aspect of it.

Mr. **Gibbons**. You sure must be nice to work for.

Chairman **Pickle**. Thank you, Mr. Gibbons.

We thank you, Ms. Walters, Mr. Finch, and Mr. Gandhi. We appreciate your testimony very much.

The Chair announces that we will have a 5-minute recess as we get ready for the next hearing, which will be with the Commissioner of Internal Revenue Service, Mr. Egger. There will be a 5-minute recess.

[Whereupon, at 11:35 a.m., the hearing was adjourned.]

[Submissions for the record follow:]

STATEMENT OF J. RANDY ADAMS, PRESIDENT, ADAMS PLASTICS, INC., COOKEVILLE, TENNESSEE

Mr. Chairman. Thank you for the opportunity to comment on the affects of the current products liability insurance crisis.

Adams Plastics began in 1948, when my father invented the face guard to protect a young athlete's mouth while playing varsity football at Tennessee Technology University. The young man had a music scholarship (trumpet player), and the protection the guard afforded to his mouth was essential.

As the demand for the face guard increased, the company began to grow. My father and mother, along with their associates, worked nights in our kitchen making face guards and boxing them, so that my father could take them by the Post Office the next morning on the way to his job at the sporting goods store. Their weekends were spent travelling, calling on schools, coaches, and athletic equipment dealers.

This is the classic story of the American drean come true: where a boy from West Virginia can turn his own ideas into working products, and pursue that to the end of profitability, with the freedom that we are guaranteed in our Constitution. It is our great hope, "the great dream", the "pot of gold at the end of the rainbow"; and while we are not here today to discuss the feasibility of the American dream, I feel that it is ironic that to many, many Americans that pursuit of the American dream has led them to the slaughter house. Misinformed parties misrepresenting facts have taken advantage of loopholes to rape other Americans, in the sole pursuit of financial gain.

"Liability insurance crisis" is a very popular term in 1986. But to sporting goods manufacturers, it has been a nightmare for years. The Sporting Goods Manufacturers Association is a group of individual companies, many of which were born in the same way as Adams Plastics. While the products will vary, many of the origins are somewhat similar, in that an effort to fill a void and to help where it was needed, sometimes voluntarily, evolved into a business.

The reason I am telling you this is to emphasize the entire impact of this crisis which we are now discussing. The very man who originated the face guard, and the very company which he founded, had to destroy all remaining face guards in inventory in early 1977 because of a lack of liability insurance being made available to us.

In our efforts to manufacture products of the finest quality, made with American labor and American raw materials, we, as all other sporting goods manufacturers, have found ourselves put upon a pedestal to be the victims of the "uninformed public". While for a time liability insurance was bought, risks were calculated, and the costs were passed on to the consumer, and a bearable existence was sought, this is no longer the case. The words for liability insurance have gone from expensive, to ridiculous, to prohibited. In our situation, liability insurance coverages were denied in 1977, through 1981. After we finally convinced our insurers that we were out of the face guard business, they agreed to write our coverage beginning at $3,952 for an additional $2 million umbrella policy in 1981; to $12,000 for a $5 million coverage in 1984; to a total of $187,000 for $1 million worth of coverage in 1985. This was the only insurance company in 1985 that would quote our company for products liability insurance.

We are not discussing here a company that is riddled with law suits, or that has a legal department just to handle the amount of claims against its products. We are discussing here a company which has never had a claim against it or awarded settlement in all the years of business. Yet, we are subject to treatment as one who makes its living by scandalizing the American public, and visualized as selling products that we know are defective and laughing all the way to the bank.

The classification of "sporting goods" has also been tagged to another company, Adams Equipment. Adams Equipment is a manufacturer of horse equipment, with products ranging from horseshoes to rope bags for the rodeo cowboy. With never a single claim filed against this company, liability insurance was denied, due to the sporting goods classification being placed on our products.

You have heard the complaints for days and weeks from all walks of life about how liability is choking the Nation, and how it will soon be the death of American business. But let's look for a moment to the positive side of the issue. Because of liability there are certain words that are no longer in our vocabulary: protects, protection, shield from injury, pads from injury. We are forced to play games with the English language so that in simple, honest conversation we do not incriminate ourselves by using one of those forbidden words that could be used against

us at a later date. But think for a moment: if we could use those words, and if we could openly discuss the proper usage of padding, the proper fit of a helmet. If we could, without making ourselves liable, view films of injuries and work with injured athletes and doctors to be able to solve some of the possible problems that may exist.
Then, instead of hiding from possible inadequacies in protection, we can work to do a better job at our profession, and to lessen the severity of all injuries, with the ultimate goal of injury-free athletics in front of us.

Positive strives could be made to obtain such a goal, even as elusive as it may sound. We would no longer have to be subjected to being raped in the name of justice, because we made an honest and sincere effort to do the very best we can with the technology that we presently have available to meet the demands of today's athletics. And, while all this sounds well and good to the ear, and looks nice on paper, it has no value whatsoever unless it is acted upon immediately, and reversal of the status quo is imminent. Because the root of the problem is greed, one of the longest running problems of mankind.

We can talk about liability caps, we can discuss the court system, or we can eliminate athletic participation completely. The problem will continue until the government takes positive action to solve it at the source. Liability is soon to be the death of the American free enterprise system, if swift action is not taken. Every minute that ticks by on a clock that we do not move towards that goal, puts another nail in the coffin of the American dream, and quietly chokes our sweet freedom that so many have died to preserve.

I sincerely thank you for your time.

American Bar Association

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FOR THE RECORD

March 12, 1986

RECEIVED
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Ways and Means
Subcommittee on Oversight

The Honorable J. J. Pickle
Chairman, Subcommittee on Oversight
Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

We appreciate the invitation you have extended to the American Bar Association to testify at upcoming hearings of your subcommittee dealing with the costs and availability of liability insurance. While the Association has a keen interest in the area of tort liability, and has done studies and adopted policy positions on a number of tort issues, it has not adopted policy on the issues which are the subject of the hearing. Therefore, we will be unable to provide a witness.

However, we would like to call to your attention the studies and policy resolutions which have been developed by our Association in recent years.

In 1979, the ABA's Board of Governors created the Special Committee on the Tort Liability System with a charge to present a "review of the tort liability system that would focus on: (1) "the present-day validity of the tort liability system in dealing with claims for physical injury," defined to include property damage; (2) "the strengths and weaknesses of the system in today's legal and social environment"; and, (3) "the consideration of appropriate modifications or alternatives to the current system aimed at curing identifiable defects while preserving the recognized strengths."

After five years of study, the Committee produced the enclosed 981-page report entitled "Towards a Jurisprudence of Injury: The Continuing Creation of a System of Substantive Justice in American Tort Law." The views represented in the document have not been considered by our House of Delegates and therefore are not ABA policy but represent only the views of the Special Committee on the Tort Liability System. Also enclosed is a summary of the report.

Subsequent to the Committee's five-year study, the ABA has continued and will continue to study problems in the tort liability system with an eye toward making recommendations on how it can be improved. Publication of the report was followed by an ABA-sponsored conference on the tort liability system in Lexington, Kentucky. The conference, held to discuss where tort law is and should be heading, involved 120 lawyers, trial and appellate judges and academic leaders representing the full range of views on tort law improvement.

In November of 1985, ABA President William W. Falsgraf appointed an Action Commission to Improve the Tort Liability System which expects to make policy recommendations to our House of Delegates in February, 1987. The Commission, composed of distinguished lawyers, law professors and federal and state judges, will study the recommendations in Chapter 13 of the report of the Special Committee on the Tort Liability System as well as other studies of the tort liability system. Enclosed is a list of the members of the Action Commission.

The ABA has adopted the enclosed policies on federal product liability legislation and recently adopted the enclosed policy on malpractice legislation. If you would like us to provide you with additional information on these policies, please let me know.

Sincerely,

Robert D. Evans

Robert D. Evans

APPENDIX A

RESOLUTION OF THE HOUSE OF DELEGATES
OF THE AMERICAN BAR ASSOCIATION
ADOPTED FEBRUARY, 1983

I. BE IT RESOLVED, That the American Bar Association opposes enactment of broad federal legislation that would codify the tort laws of the 50 states as they relate to product liability, and opposes legislation, such as S.2631 reported by the Senate Commerce, Science and Transportation Committee in the 97th Congress, that would attempt to do so.

II. FURTHER RESOLVED, That the American Bar Association supports federal legislation which addresses the issues of liability and damages with respect to claims for damages against manufacturers by those who contract an occupational disease (such as asbestosis) when: (a) there is a long latency period between exposure to the product and manifestation of the disease; (b) the number of such claims and the liability for such damages in fact threaten the solvency of a significant number of manufacturers engaged in interstate commerce; and (c) the number of such claims have become clearly excessive burdens upon the state and federal judicial systems.

III. FURTHER RESOLVED, That the American Bar Association supports enactment of federal legislation allocating product liability risks between the federal government and its contractors and providing, in certain instances, indemnity against those risks.

APPENDIX B

RESOLUTION OF THE HOUSE OF DELEGATES
OF THE AMERICAN BAR ASSOCIATION
ADOPTED FEBRUARY, 1981

BE IT RESOLVED, That the American Bar Association opposes enactment of legislation such as H.R. 7921, 96th Congress, which would impose a Model Products Liability proposal as federal law.

APPENDIX C

RESOLUTION OF THE HOUSE OF DELEGATES
OF THE AMERICAN BAR ASSOCIATION
ADOPTED FEBRUARY, 1986

1. BE IT RESOLVED, That the American Bar Association urges appropriate ABA entities, such as the Action Commission to Improve the Tort Liability System and the Commission on Professionalism, to continue to consult, where appropriate, with representatives of the American Medical Association and others in the health care industry, the insurance industry, state and federal governments and appropriate segments of the public with the goal of seeking a broader consensus on how more equitably to compensate persons injured in our society. The problems associated with medical professional liability are common to all areas of tort law and should be evaluated in the context of their broader implications for the tort system as a whole. The Legal and Medical professions should cooperate in seeking common solutions to these problems and should avoid any efforts to polarize the discussion of these problems, which would serve neither the public interest nor the interests of either profession.

2. FURTHER RESOLVED, That consistent with these goals, the American Bar Association adopts the following principles:

A. The regulation of medical professional liability is a matter for state consideration; and federal involvement in that area is inappropriate.

B. There should be rigorous enforcement of professional disciplinary code provisions which proscribe lawyers from filing frivolous suits and defenses; and sanctions should be imposed when those provisions are violated.

C. There should be more effective procedures and increased funding to strengthen medical licensing and disciplinary boards at the state level; and efforts should be increased to establish effective risk management programs in the delivery of health care services.

D. No justification exists for exempting medical malpractice actions from the rules of punitive damages applied in tort litigation to deter gross misconduct.

E. No disclosure of financial worth by a defendant in a tort action should be required unless there is a showing by evidence in the record or proffered by the plaintiff that would provide a legal basis for recovery of punitive damages.

F. Notices of intent to sue, screening panels and affidavits of non-involvement are unnecessary in medical malpractice actions.

G. No justification exists for a special rule governing malicious prosecution actions brought by health care providers against persons who sued them for malpractice.

H. Trial courts should scrutinize carefully the qualifications of persons presented as experts to assure that only those persons are permitted to testify who, by knowledge, skill, experience, training or education, qualify as experts.

I. The collateral source rule should be retained; and third parties who have furnished monetary benefits to plaintiffs should be permitted to seek reimbursement out of the recovery.

J. Contingent fees provide access to the courts; and no justification exists for imposing special restrictions on contingent fees in medical malpractice actions.

K. The use of structured settlements should be encouraged.

L. Collection and study of data on the cost and causes of professional liability claims should be undertaken to evaluate and develop effective loss prevention programs.

APPENDIX D

MEMBERS OF THE ACTION COMMISSION TO IMPROVE THE TORT LIABILITY SYSTEM

The Commission is chaired by Robert B. McKay, President of the Association of the Bar of the City of New York. McKay is also a Professor of Law at, and former Dean of the New York University School of Law.

Other members of the Commission are the Honorable Shirley S. Abrahamsom, Justice to the Supreme Court of Wisconsin; Jane Barrett, a partner with Lawler, Felix & Hall, Los Angeles; Guido Calabresi, Dean, Yale University Law School; the Honorable Jim R. Carrigan, United States District Court Judge, Denver; Thomas S. Chittenden, Senior Vice President and General Counsel of the American Insurance Association, New York City; Leonard Decof, Decof & Grimm, Providence; Elaine R. Jones, attorney with NAACP Legal Defense and Educational Fund, Inc., Washington, D.C.; Thomas Lambert, Professor of Law, Suffolk University Law School, Boston; Stephen B. Middlebrook, Vice President and General Counsel, Aetna Life & Casualty, Hartford; Henry G. Miller, Senior Member of Clark, Gagliardi & Miller, White Plains, N.Y.; Alan B. Morrison, Director, Public Citizen Litigation Group, Washington, D.C.; the Honorable Jon O. Newman, United States Circuit Judge, United States Court of Appeals for the Second Circuit, Hartford; and John T. Suback, Vice President and General Counsel, Rohm and Haas Company, Philadelphia.

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APPENDIX E

TORT REPORT -- MEDIA SUMMARY

While there apparently is "no word in the Bible for torts," several verses of Exodus that follow the Ten Commandments "are filled with what we think of as 'tort' rules."

This historical long view begins the Report of the ABA's Special Committee on the Tort Liability System. The title of the Report, reflecting its ambitious scope, is "Towards a Jurisprudence of Injury: The Continuing Creation of a System of Substantive Justice in American Tort Law."

One major landmark which the Report represents is that it is a comprehensive systemic review.

A second major accomplishment of the Report is that it represents an effort to describe, as a whole, how American law and society respond to injuries. While focusing on the law of torts, the Report sets the tort liability system in the context of an even broader system of law, a mechanism that society continues to evolve in an effort to do justice both to those who engage in risky activities and those who are injured by them.

A third principal element of significance is that while taking a systemic view and presenting recommendations that often emphasize procedural reform, the Report concludes by emphasizing the role of tort law in the "continuing creation of a system of substantive justice, with all the complexity that term implies, for disputes caused by a multitude of injuries." [14-12.]

Against this broad background, the Report weaves a number of themes which capture both the social tensions to which tort law responds and the richness of the response. These include:

- The tension between individualized responsibility and socialized responsibility for injuries.

- The service performed by the adversary system of justice, and the phenomenon of judges and juries working together to render individualized justice.

- Quite importantly, the plurality of rationales for tort decisions among which judges select in fashioning substantive tort rules.

- The relation between common law tort decisionmaking and comprehensive compensation statutes, such as workers' compensation laws, as well as the relation between common law decisionmaking and public regulation of dangerous activities.

- The relationship between tort law and the political process.

- The role of tort law as a lubricant in a complex society with many stratifications and many fault lines.

- The trade-offs between doctrinal and functional approaches to the law.

- The relation of tort law to the work of scholars in other disciplines, including economic theory and social science studies of behavior.

- The role of courts as dispensers of individualized justice in an historical tradition that stretches back to Biblical times.

* * *

The often historical flavor of the Report, as well as its emphasis on tort law as a working barometer of American views of substantive justice, appears in the first chapter. The text of that chapter declares that it is "no coincidence . . . that the blossoming of tort law has occurred parallel to the rise in complexity of economic ordering and techology, as well as the evolution of the modern city." Sounding a theme to which it returns in later chapters, the Report says that "tort law has been a response to all of these developments, providing some suppleness in the joints of the legal system as events place strains on the social order."

In general, the Report emphasizes the role of tort law as "a mirror of American society, held up to some of its most difficult moments of private conflict." [1-1.] A related, recurrent theme of the Report appears in the observation that "an important attribute of this area of legal doctrine is its ability to provide a simplified medium for translating into law the substantive reactions of ordinary people to complex events." [1-2.]

* * *

These themes continue in the second chapter, in which the Report refers to "tort law as an epicenter of jurisprudence, not simply as a set of guides and standards for the decision of many thousands of private law suits, but as a reflection of how American society feels about justice at dozens of focus points of social tension." [2-2.] In this second chapter, the Report defines the quantitative dimensions of the problems to which tort law responds. Summarizing statistics, the text observes that criticism is often directed to the amount of the insurance premium dollar that does not find its way into the pockets of injury victims. [2-2.] However, the Report also notes the difficulty of identifying the costs associated with tort cases, as "illustrated by the wildly varying estimates of the number of products liability suits -- in one year varying from as few as fifty thousand to as many as one million." [2-1.]

In defining "tort," the Report notes the wide range of events to which tort law applies -- ranging from auto-pedestrian collisions and defamatory media publications to actions for professonal malpractice and batteries commited by private citizens against one another as well as by police officers against private citizens. [2-7.]

After describing various competing approaches that scholars of the system have taken to tort law, the text sounds a theme that becomes enormously amplified in Chapter 4: "The virtues of American tort law include an approach that is both telescopic and pluralistic." [2-17.]

In defining the problems that critics see in tort law, the Report notes that tort defendants, such as physicians and products manufacturers, express frustration about perceived uncertainties in the law and the contradictions inherent when courts arrive at different results in substantially identical cases. [See 2-23-26.] However, this preliminary analysis of problems associated with tort law asks "whether there are significant differences in the way the tort law generates these concerns as compared with the uncertainties and contradictions inherent in other bodies of legal doctrine in a federal system serving 200 million persons." [2-27.]

* * *

The third chapter of the Report addresses itself, in a way accessible to lay persons, to the question of "what tort law means in American society." It points out that a "principal function of tort law in American society has been vindication of certain personal rights." [3-1.] Some courts have been articulate about the relation of certain tort doctrines -- notably the law of invasion of privacy -- to the character of American society. Thus, the Report quotes a federal court of appeals in a privacy case to the effect that "fairly defined areas of privacy must have the protection of law if the quality of life is to continue to be reasonably acceptable." [3-2.] The Report also notes how tort law's concern with efficiency facilitates the workings of a market economy. [See 3-10-13.]

Using analogies drawn from sports, the Report defines the role of tort law as a "grievance mechanism," providing "a brake on the overt conflict that may break through the crust of civilization when injury victims have reason to believe that society is not responding justly to their plight." [See 3-16-18.] Paralleling this analysis is the Report's suggestion that tort law's "role as an interstitial bonding agent is a significant one," "exert[ing] a subtle but pervasive influence on the views of hundreds of interest groups and tens of millions of persons, concerning right behavior," and thus "serv[ing] an important normative function." [3-22.] Referring to one of the newest tort theories, the Report says that this category "represents a concretization of values and a declaration that certain conduct is a wrong because it is wrong." [3-29.]

* * *

The long fourth chapter of the Report, entitled "The Purposes and Policy Goals of Tort Law," is technical in its detail but in its broad outlines quite understandable by non-lawyers. This chapter identifies as many as two dozen elements of tort decisions which go under the heading of "purposes, goals, rationales and values." This lengthy catalog of the ideas on which courts draw in judging tort cases emphasizes the "pluralistic nature of tort law and the complexity of the human universe to which it responds." [4-1.]

An illustration of the complexity of tort rationales appears in the first two subchapters of Chapter Four, which define two different meanings of "deterrence," a concept often associated with tort decisions. On one hand, courts appear to be exhibiting a "commitment to increased safety without precise calculations of cost." [4-3.] On the other hand, judicial concern with deterrence sometimes appears not as "an abstract commitment to reducing accidents" but rather an effort to "optimiz[e] accident costs," in the sense that there is "an economically efficient level of accidents, and indeed it would be uneconomic if too few accidents occurred." [4-13.] "The common sense of an efficiency approach" often appears in statements like "vehicle manufacturers have no duty to make their products 'accident proof or fool proof.'" [4-17.]

Another major set of rationales for tort decisions is apparent in judicial efforts to provide "compensation" for injury victims. Compensation in this sense evidently has several meanings, including a "way to make tort victims 'whole,'" a function of providing income maintenance for injury victims, and finally, "a means of achieving 'fairness.'" [4-29.]

The concept of "fairness," indeed, provides one of the foundations of a discussion of the "avowed ethical bases of tort law," including references to judicial and scholarly language that fixes on ideas of "justice" and "morality." The Report notes, in this connection, that "it would be surprising if a society with part of its roots in Massachusetts Bay and Plymouth Colonies, indeed with much deeper antecedents in several powerful religious traditions, did not have a law of injuries that directly reflects ethical concern." [See 4-153-166.]

Other concerns addressed in this complex chapter include tort law's effort to respond to "the dynamic nature of an increasingly technological society" [see 4-59-65], and to the effects of "a system of mass production and distribution" [4-71], specifically including the impact of advertising. Making detailed reference to case law, this subchapter shows how tort decisions provide "a response to advertising that takes in the many varieties of modern selling techniques, from retailer newspaper advertisements to tools of electronic communication often used by national manufacturers." [4-81.]

Among other elements in its discussion of the rationales of tort law, the Report notes that "a significant element in the background of tort cases, not always articulated in the decisions, relates to the defendant's ability to exercise control over the person or affairs of the plaintiff." In this sphere of judicial activity, the Report concludes that courts seem to be "saying that when one person attributes injury to another's misuse of his power to dictate vital circumstances of the first person's life, or occasionally when one ascribes his harm to a failure to use such power, there are limits to judicial willingness to enforce marketplace mores." [4-116, 119.]

The chapter closes by echoing earlier themes, suggesting that the pluralism of tort rationales reflects tort law's "special vocation in a society of great heterogeneity with a high degree of freedom," and declaring that "the way that tort law resolves its inner tensions provides an important reflection of the quality of American justice generally." [4-219-220.]

* * *

The fifth chapter of the Report surveys several areas of substantive tort law which provide "prisms" [5-2] for the resolution through law of individual disputes. This chapter focuses on several areas of law that are particularly in the spotlight of national concern and publicity, but also uses some other areas of law as examples of the way that "tort law sends a signal to all citizens, from business doers to pleasure seekers, about appropriate standards of conduct." [5-2.]

Highlights of this chapter, in which different sets of tort rules are used to illustrate various features of the tort system, include the following:

- The law of invasion of privacy indicates the "profundity" of judicial convictions concerning the "intangible interest in personal integrity" to which that branch of law responds, but also the importance of "society's continuing interest in obtaining information about its members." [5-6-7.]

- The doctrine of express assumption of risk reflects the "strong strain of belief" in the American character that "it is not only economical, but just, to enforce on people their selections of packages of risks and benefits, chosen freely at a price." Some cases, however, also reflect "judicial assessments that in some cases the party attempting to shift the risk has not made that fact clear, and that in other cases it has acted unfairly." [5-32.]

- The discussion of the doctrines of implied assumption of risk and contributory negligence show how, "in a regime of injury law which is largely fault-based," a system of individualized justice draws on "notions of individual responsibility which ground many of our basic conceptions of justice." The pragmatic character of tort law appears in the Report's conclusion that "in assigning to local judges and juries questions of the responsibility of injury victims as well as injurers, the system forges important links between the law and the views of ordinary citizens." [5-42.]

- The Report's analysis of the doctrine of nuisance "symbolizes . . , tort law's function as a free-standing private check on clusters and governmental and private power." This section also epitomizes the role of tort law "as an independent body of grassroots legal wisdom, and . . . a residual refuge for the injured citizen" in cases where regulatory statutes do not provide sufficient protection to those injured by such activities as pollution-generating behavior. [See 5-64-65.]

- The discussion of medical malpractice law utilizes the controversy about whether the standard of care for physicians should be locally or nationally defined to illustrate how "courts deciding tort cases have made clear that they will be the arbiters of minimum standards, giving consideration to the realities of reliance and of the availability of consumer as well as provider information, and crediting general notions of individualized justice." [5-73-74.]

- The discussion of "informed consent" in medical malpractice law analyzes the way in which courts employ that doctrine to protect patients' dignitary interests while recognizing the realities of medical practice. [See 5-77-84.]

- A detailed chapter on products liability describes the judicial use of doctrines ranging from "misrepresentation" to "implied warranty" to "strict liability in tort" to respond to the growing technological complexity of consumer goals and to the sophistication of the advertising regime which generates product sales. [See 5-88-102.]

- The Report's discussion of the question of whether psychotherapists must warn possible victims of the potentially dangerous conduct of patients provides an illustration of the "mediating role of tort decisions" in situations where important individual and social interests clash, sometimes creating novel legal problems. The Report does not make a substantive judgment on appropriate rules in this kind of case, but rather utilizes developments in this area of liability as representations of tort law's role as "a first sentinel for society's evaluation of injury-causing occurrences." In carrying out that mission, judges are front-line combatants in "trying to solve the questions of interstitial social conflict typical of tort litigation." [See 5-117-118.]

- A detailed analysis of tort damage rules focuses, in part, on the controversy about damages for pain and suffering. The Report says that this issue "embodies tensions between popular intuitions and conflicts among common rationalizations," but "find[s] significant . . . the universality of judicial acceptance of damages for pain and suffering." That judicial unanimity, the Report says, "appears to carry a message about community sentiment" concerning the propriety of that element of damages. [5-182-183.]

- While noting that there is plenty of room for argument about particular applications of punitive damages, the Report concludes that in general "punitive awards play a mediating role between tort and criminal law that is worth preserving." With respect to possible abuses of punitive damages, the Report says that "judges possess adequate tools to control the potential for unfair application." [5-195.]

* * *

A survey of representative issues not covered by substantive tort rules includes a section concerning the controversy about lawyers' fees in tort cases, specifically dealing with the contingent percentage fee. Noting various criticisms of contingent fees, including the argument that they are poor measures of "both the cost to the lawyer and the value to the client of the legal services rendered," [6-30], the Report points out that contingent fees "permit claimants without capital to test the law against the facts of their cases." The contingent fee thus not only helps to promote individual justice but provides an "ability to try worthy cases" that "promote[s] the policies of tort law, such as its deterrence goals." [6-29.] The Report concludes that "judicial capacity to scrutinize fee arrangements is, in the main, sufficient." [6-36.] It suggests that the expansion of client ability "to acquire information about the price and quality of legal services" will permit injury victims to choose legal fee arrangements that best approximate "their own risk preferences." [6-37.]

* * *

In analyzing some of the relationships of tort law and liability insurance, the Report takes note of the argument that the combination of liability insurance and tort law produces an unfair system of injury compensation. [7-31.] Yet with reference to the criticisms of litigation costs as they relate to liability insurance, the Report points out that the tort system does not differ from other branches in the law with respect to the need for "potential claimants" to "make judgments comparing the costs of injury, the expense of pressing suit, and the probable worth of a recovery." In this regard, the Report reiterates that "the contingent fee system appears to be a reasonable method for screening out claims not appropriate for litigation." [7-32.] Generally, the Report concludes that "the insurance mechanism, although flawed, reinforces notions of individual responsibility while it spreads risk." [7-35.]

In assessing the process of decision, the Report focuses first on the adversary system as a method for dealing with tort cases. While drawing on scholarly literature that speaks of "a conception of procedural fairness that is realized uniquely in an adversary system," [8-5], the Report summarizes criticism of the "gamesmanship" of the system which "produce[s] negative effects, including behavior which borders on and occasionally constitutes unsportsmanlike conduct." [8-6.] However, it concludes that "in situations of high conflict, the evidence indicates that the adversary system is the best mode of dispute resolution." [8-9.] The Report points out that many of the specific criticisms leveled at adversary justice involve conduct exhibiting "disobedience to the simplest ethical precepts, in many cases offenses which are subject to policing through the present system or feasible modifications of it." [8-10.]

Extending this analysis to the jury, the Report concludes that "both the larger system and the jury confer great social benefit, and merit preservation as working institutions." [8-25-26.] While summarizing numerous criticisms of the jury, the Report notes that leading scholarship, as well as anecdotal reports on jury service, emphasize that jurors do understand cases and bring to their judgments a sense of equity and humanity. [See 8-15-23.] The Report generally approves the jury as a working institution, but draws on the ABA's standards relating to juror use and management for several specific reform recommendations. [See 8-24-25.]

* * *

Chapter Nine of the Report, which summarizes some of the literature on whether and how tort law affects conduct, suggests that "an increasing concern with behavioral facts will accompany a sharpening judicial focus on the effects of legal rules." [9-14.] This chapter utilizes the case of employee decisions to encounter job-related dangers as an illustration of "the sorts of issues that demand judicial assessment of behavioral hypotheses." [9-13.]

* * *

The lengthy tenth chapter of the Report sets tort law firmly in the context of the developing "jurisprudence of injury." It relates common law tort doctrine to other tort-like rules of decision, including the "constitutional tort" developments under the anti-Ku Klux Klan legislation in the Civil Rights Act of 1871, now codified as 42 U.S. Code section 1983. [See 10-10-15.]

The Report also relates tort law to other fields of common law, including contract law and property law. [See 10-20-40.] Among other virtues of tort doctrine, it finds not only "the steadying tendencies associated with all doctrine," but the advantage of a supple response to new situations. [10-25.] The Report emphasizes, resounding a recurrent theme, that "in a world of increasing concern about the dehumanizing effects and negative philosophical implications of collectivist solutions," tort law provides a mediation "between socialization and individual justice." [10-25-26.]

A principal feature of the Report's relation of tort law to its legal neighbors is the subchapter analyzing workers' compensation. Recognizing that "as a matter of practical politics, workers' compensation seems here to stay" as part of America's "pluralistic approach" to the injury problem, the Report suggests that "comprehensive compensation legislation . . . may be inferior to the reasoned development of judge-made law and indeed . . . will often create employment for lawyers." [10-58.]

Another section of Chapter Ten relates several regulatory statutes to tort law. While noting that the Occupational Safety and Health Act "arguably provides prophylaxis for problems which tort law cannot practically reach," the Report points out that "tort law contributes an important ingredient which administration of the Act sometimes lacks: A reasoned, incremental development of law over time through a process relatively insulated from political pressure." [10-88.]

The Report views tort law as providing a complement to federal food and drug law, sharing with that body of regulation something of a deterrent function, but also providing compensation and "most generally, the fulfillment of a community sense of individualized justice" in injury cases involving food and drug products. With respect to national motor vehicle regulation, the court notes that the federal statute "cedes to judges an important independent role in the determination of acceptable levels of vehicle safety," and refers to "the prolonged stalemating of passive restraint regulations, as well as other regulatory delays in the resolution of defect disputes," as "symbols of why this division is a sensible one." [10-116.]

Noting the "uneven" progress of the Consumer Product Safety Commission since it was set up in 1972 [see 10-125-129, 130], the Report suggests that "our tort law, sometimes criticized both for its incrementalism and for the variations of its results within a federal system, is an admirably stable legal institution," drawing strength "from its process of reasoned articulation." [10-138.]

When it comes to the case of cigarettes, the Report notes the general lack of success of tort litigants who have tried to ascribe illness to smoking. The Report concludes that "in an area denominated 'the most important public health issue of our time,' the problem of law and policy is commensurately political," and that "it is public law that virtually occupies the field." [10-142.]

In generally relating tort law to other branches of the law -- both public and private --the Report concludes that the "linkage of tort law with other legal regimes" provides a "framework for a powerful system of justice."

* * *

Looking both backward and forward in the Report, Chapter Eleven declares that tort law, because of its origination "in fierce disputes about events alleged to be 'wrongs,'" "provides a special link between ordinary citizens and the legal system." [11-2-3.] The Report deals at some length with four areas of present controversy about the role of tort law. It features, among others, the following conclusions:

- While modified no-fault automobile insurance statutes have some desirable features, and represent rational if not necessary policy choices, it is crucial that tort remedies be preserved as injuries become more severe. Not only is there is some evidence that tort law has significant deterrent effects on automobile accidents, but, the Report says, one may assume that "the tort system provides an important psychological outlet for seriously injured victims." [11-19.]

- The tort approach "provides a significant, and necessary, deterrent against incompetent and careless rendition of medical services," as well as "confer[ring] intangible benefits, for example in citizen perceptions of the justice of imposing liability on those culpably responsible for injuries." The Report says that "if the tort system offers these benefits imperfectly," it can find "no evidence that alternative general approaches would be superior" either as a matter of economics or justice. [11-32.]

- With respect to the heated controversy over current proposals for a federal products liability statute, the Report "emphatically commend[s] the process for resolving legal disputes about products injuries . . . through state-oriented liability law." It says that "the heralded benefits of a general federal codification are likely to prove illusory," that such a law may well generate increased litigation, and that surely it will politicize a branch of law which the courts over a period of twenty years have developed in a nationwide judicial dialogue. [See 11-39-48.]

- Speaking of the expanding category of tort cases dealing with toxic products, particularly in areas covered by the Superfund legislation, the Report says that "a large segment of the task of deterrence . . . require[s] legislative action." However, it suggests that there is room for an improved response of tort law to the "toxics" problem. This response would include -- as suggested by the Superfund Study Group -- the improvement of tort remedies and the removal of procedural barriers to recovery. [11-62, 59.] While indicating that the "chief effects" of an expanded tort law in the "toxics" area may be principally "to highlight ethical norms," the Report says that "an enhanced tort response . . . will tend to make producers and sellers more conscious of the need for risk prediction and management."

* * *

Chapter Twelve of the Report undertakes specifically to assess the strengths and weaknesses of the tort liability system. It reiterates several of the features of the tort system that appear as themes in the Report:

- The way "it provides a grassroots response to the injuries typical of our complex society . . . with a flexibility that allows individualized justice to be rendered." [12-1.]
- The way it "provides the incremental wisdom of a common law process." [12-2.]
- Its provision of "a forum in which individuals can feel that their substantive rights have been judged." [12-2.]
- Its "role in knitting together, and mediating, the goals of compensation statutes and regulatory laws." [12-3.]
- Its function as a "lubricating agent, reducing social friction," its role as "a mirror of morals," and the way in which "by virtue of its versatile service of multiple social goals, tort law provides justice in a pluralistic society." [12-4-5.]

Among the criticisms and alleged needs for improvement which the Report identifies are these:

- The perception that the operation of tort law shifts too much money from defendants to plaintiffs.
- The administrative costs of the system, particularly those associated with delay.
- The need for collection of data about the injury problem and its social, economic and legal consequences. [12-9.]

- The "allegedly inefficient influence" of tort law on productive activity. [12-9.]

- The contentions that some tort rules create undesirable incentives for people to take risks, as well as incentives for fraud and frivolous claims. [12-10-11.]

- The argument that the tort system "contributes to an uneasy public perception that our courts produce a significant amount of injustice."

* * *

While stressing "the role of tort law as a facilitator of the progress of a free society, in which citizens grow up with a healthy sense of right as depending on law," the Report sets forth numerous recommendations and suggestions for improvement. A principal focus of these recommendations is "on ways to improve the administration of justice as it relates to the tort liability system." Recommendations for systemic improvements include the following:

- "The creation of a permanent organization for the comprehensive collection of data on injuries and injury-causing events, and the ways in which individuals, communities, and the legal system respond to the problems created by injuries." [13-1.]

- A recommendation "that both state and federal courts experiment vigorously with procedures for more effective dispute resolution." The Report emphasizes "litigant choice of dispute mechanisms, for example favoring mediation over arbitration." [13-3.]

- Several recommendations for the improvement of judicial efficacy, ranging from the development of manuals for effective case management to significant increases in judicial salaries and additions of more courts and judges where necessary. [13-4-7.]

- Increased emphasis on judicial discipline of attorneys who bring litigation without arguable merit. [13-7.]

- The convocation of a group of litigation experts to formulate recommendations for increasing incentives to settle cases. [13-8.]

- A suggestion that the uniform commissioners on state laws "consider devising highly specific uniform laws as responses to particularly vexatious tort issues," as well as a suggestion for the establishment of a "perennial judicial conference on substantive law problems," with a view toward promoting uniformity in American tort law. [13-9.] In this regard, the Report notes that the "evolution of products liability law" through the "cross-country conversation among state and federal judges" implies the "potential value of such an ongoing enterprise" in "expediting progress toward reasoned uniformity." [13-8-10.]

- The Report notes that "exceptional circumstances, for example those arising from catastrophic occurrences or from chains of events otherwise generating many cases with closely related facts, may require the development of special procedures for the resolution of injury disputes." While identifying a possible need for such procedures in cases like those stemming from asbestos-caused illness, the Report "emphasize[s] that the institution of special procedures will be justified only by the most unusual circumstances." [13-10-11.]

Among the recommendations and comments dealing with specific areas of current concern in tort law, the Report mentions:

- "A need to improve the law's response, in several jurisdictions, to the problem of injuries which occur or become evident many years after the defendant's last tortious act." The Report recommends that statutes of limitation "should expressly allow time for suit after claimants reasonably could have discovered the relationship of the defendant's act to their illness or injury." [13-14.]

- While indicating the desirability of punitive damages as a tort remedy, the Report indicates that "many courts must provide closer reasoning about why they impose punitive damages and how they review such judgments." It suggests that in situations involving large numbers of lawsuits growing out of a single event or business decision, there "remains work to be done in formulating rules which limit punitive damages . . . to amounts that serve the policy goals to which those sorts of damages are referable." [13-15-16.]

- The Report generally approves pain and suffering damages as "properly an integral part of the American tort damages law." It also approves the "collateral source rule," which permits tort claimants to retain benefits paid by others, noting in that connection that insurers may employ subrogation clauses in a way that "reduces the total social expenditures" associated with tort cases. [13-16-17.]

- While approving the imposition of joint and several liability against multiple tortfeasors, the Report suggests the need for rules, particularly rules of contribution, that reduce undesirable pressures on jointly sued parties to settle even where their defenses are strong on the merits. [13-17.]

- In considering the legal problems at the border of tort law and workers' compensation, the Report observes that tighter rationalization of this area of the law "requires clearer definition of premises about the relationship" of tort rules and compensation statutes. [13-18.]

The Report's recommendations and suggestions conclude with an exhortation to firms that engage in risky activity to designate officials to deal with problems of risk management or loss control. "For many businesses," the Report says, "the key to solving the injury problem lies in taking a more business-like approach toward preventing injuries." [13-20-21.]

* * *

Concluding the Report, Chapter Fourteen scans a history ranging from the codes of Biblical times and the law of the tribes of ancient Britain "to the technical cut and thrust of the trial court in Chicago or Kalamazoo, and to the stern formality of appeals courts in Sacramento and Lincoln and Trenton."

The Report's predictions for the future suggest that "tort trials will continue to provide models for courts and lawyers engaged in the ongoing process of developing a system of substantive rules," "provid[ing] signals on which cases to accept, which ones to try, and those which are ripe for settlement."

The Report predicts that once systemic reforms free the tort system to do its job, it "should do it even better." As a general matter, the Report speculates, the major substantive areas of tort law "will look surprisingly similar" in the law books of the next century.

The Report forecasts "an increasingly significant role for tort law as an agent of response to the socially undesirable use of power." [14-7.] The text also reiterates its skepticism of "wholesale legislative revision of tort law," including products liability law [14-9], as well as its "opposition to the importation of full-scale legislative compensation schemes for all tort-like injuries." [14-10.]

This concluding chapter "emphasize[s] the role of lawyers in serving a people for whom individual justice remains an intense concern and access to courts a prized right," saying that "for Americans, tort law provides a bulwark against assaults on personal rights as well as a steadying influence in the midst of swings of the political pendulum."

Elaborating this point, while the text expresses a sensitivity to complaints that America has become "overlawyered," it notes the coincidence of the appearance of the Report in the year for which Orwell's novel 1984 is named. Speaking "in the spirit of the novel," the Report suggests that for one who feels seriously "wronged," the response "I'll see my lawyer" has a much more satisfactory ring than "I'll see my bureaucrat." [14-12.]

STATEMENT OF THE

AMERICAN CONSULTING ENGINEERS COUNCIL

The American Consulting Engineers Council (ACEC) is pleased to present this statement on civil justice reform. We would like to do more than detail the tremendous difficulties that consulting engineers have in obtaining liability insurance. Therefore, we also suggest a proposed solution.

Consulting engineers have been consistently in the forefront of responding to the major challenges of this century. The great strides in transportation, communications, buildings, energy generation, pollution control and historic preservation are all dependent on engineering, most of it done by independent professional firms. Yet what do we find today?

Liability insurance is today nowhere available for hazardous waste removal engineering nor for the design of the rehabilitation of federal buildings, where asbestos is present. Firms performing structural engineering necessary for construction of dams, wastewater treatment plants, bridges, as well as public buildings, experienced an average increase in premiums of 54% in 1985.

The pollution exclusion published by the insurance industry in mid 1985 may eliminate coverage for environmental firms designing pollution control systems for water and air.

But the root cause of the crisis we believe is not in the insurance industry, but the American civil justice system. Five years ago a small minority of our firms were sued by their clients to remedy design errors or by personal injury claimants. Today it is not uncommon for engineering firms to have multiple suits at all times pending. Architectural/engineering (A/E) firms in 1985 averaged 109 new claims/100 firms and 210 claims pending/100 firms.

Not only has legal doctrine been substantially altered, the dollar value of awards has ballooned. The tort system today has more million dollar winners than a state lottery. You may think that the high awards you read about are aberrations, but in 1984 the average product liability verdict was over a million dollars. The average medical malpractice award was $950,000.

Courts today also have become more liberal in awarding punitive damages. Recently, an insurance company disputed the proper settlement amount with a couple whose car was rear-ended. The insurance company offered $4,500; the couple believed they were entitled to $17,000. They sued, claiming the insurance company had failed to settle their claim in good faith, and recovered $7.4 million in punitive damages. Regardless of who was right or wrong, the punitive damages awarded were totally out of proportion to the claim at hand.

And courts in many states are handing out extraordinary awards even where there is no physical injury, compensating the mental trauma caused by watching an injury happen to someone else, or the worry brought on by fear that an injury might occur in the future.

Huge damage awards are a recent phenomenon. The first million-dollar tort verdict was awarded in 1961. In 1984 alone, this country settled 401 cases for $1 million or more. By comparison, in the entire judicial history of Canada, there have been only six $1 million tort cases--and three of those cases, applying Canadian law, were decided by U.S. courts. No other country pays these huge amounts.

The financial cost of our tort reparations system is staggering: In 1984, the tort system was estimated to cost 37 times as much as it did in 1950. Commercial liability insurers alone spent $2.9 billion defending suits in 1983; and legal defense costs had risen to 25 cents per premium dollar, compared with 5 cents per dollar in the 1950s.

Think of it instead as the dean of Stanford Law School did--as litigation pollution, or more precisely, as a disease dramatically weakening our nation.

It's a disease with 16.6 million lawsuits in America last year. Japan had less than 1% as many. It is a disease which consumes as much as $60 billion of our GNP, and wastes some of America's finest minds, best products, most successful research and production facilities and zaps the creativity and energy of our public and private enterprises. And it's a uniquely American disease. Two thirds of the world's lawyers are in the U.S.

What are the symptoms? Lawsuits occur everywhere--sometimes for the most frivolous reasons. They are reported in any newspaper almost any day and liability awards from these suits show no relationship with fact, fault or fairness. The acute symptom of the disease is a plague of insurance policy cancellations and premium increases.

Most of the 1986 policy renewals among our members for liability insurance show increases from 50 to 900%. Furthermore, almost everyone's deductibles are being doubled and limits of liability are being reduced.

The consequences are severe for hazardous waste cleanup engineers, as well as nurse-midwives, day care centers, asbestos removal contractors, ski areas, small towns and community colleges, LP gas distributors, drug companies, landfill operators and thousands more. They must "go bare"--without insurance--because no one will write insurance at any price. They're facing bankruptcy, liquidation or the deadly game of litigation roulette. More than 13% of all ACEC firms went "bare" in 1985, but more sadly 1 in 3 of all our smallest firms either cannot afford or cannot obtain liability insurance. As a result, the public is unprotected, as well as these independent businesses.

We can't look to insurance companies to solve the problem, although there is no doubt that they need to provide the facts of their underwriting policies and management strategies. However, as middlemen, insurers are in the business of spreading risks in a society, not picking up the tab for them. Insurance is unusual in that it must price its product to cover the cost of lawsuits today and many years into the future. As long as the courts define the rules, the policies will be competitively priced to reflect those rules. If the liabilities are undefined, the insurance cannot, or should not, be written.

Finally, we cannot look to the courts alone to solve the problem. Courts are focused institutions which decide narrow cases involving the parties before them. Only occasionally do they see repercussions beyond the immediate case. If they did, they would probably not have set many of these recent precedents.

It took 25 years of case-made changes in doctrine to create the most litigious society in the world--ours. We do not have 25 years to correct it. The stakes are simply too high. So, if we cannot look to the lawyers, and we cannot look to the insurance companies, and we cannot look to the courts to solve the problem, to whom can we look? We must look to the legislators--in all 50 states and the U.S. Congress. The Commerce and Judiciary Committees are looking at many proposals.

We, however, suggest for the Ways and Means Committee's consideration a proposal to allow consulting engineers and other professionals to set up tax-exempt trust funds for the purpose of self-insurance. This was originally considered by the Senate Finance Committee in 1981 as S.1081 (HR.248). In an environment in which claims against A/E firms are ever increasing, liability insurance is an increasingly expensive, even unavailable protection, particularly in a vital field such as environmental hazardous waste cleanup. In December, 1985, only two insurance companies offered policies to new clients and all are excluding high risk activities such as hazardous waste and asbestos removal. Now there are none. An increasing number of A/E firms are practicing without liability insurance simply because it is unavailable.

ACEC strongly supports reintroduction and passage of this legislation which will provide relief in the area of liability insurance for design professionals. Because the legislation makes it possible for design professionals to, in effect, insure themselves for part of their liability losses, making it possible for some to obtain insurance for the rest, we believe this legislation is a fair and balanced solution, vital to the protection of the public health and safety. Currently all insurance premiums are tax deductible expenses. We believe retained earnings for self insurance should be treated the same way.

The proposal's imaginative approach will permit A/E firms to create and use service liability tax-deductible trust funds in order to meet the out-of-pocket first costs of settling legitimate claims and defending themselves when required. Design professionals would be allowed to use assets from trust funds for: (1) claim settlements; (2) legal or investigative costs; and (3) incidental costs for administering the trust fund.

It is important to understand that the proposal is not intended to replace insurance, but to supplement it. It is crafted as a legislative vehicle so that design firms can accumulate reserves to settle legitimate liability claims and pay for legal defenses under the levels of their deductibles without seriously disrupting cash flows. The legislation will permit design firms to, in effect, "pre-deduct" funds which become, at a later time, items tax-deductible as business expenses.

The proposal defines two categories of liability problems and provides corresponding levels of trust fund deductions for them. Taxpayers with "severe service liability insurance problems" are defined as those who can obtain such insurance, but only at the cost of a premium in excess of two percent of their gross receipts for a year.

Those having "severe" problems would be permitted to make annual contributions limited to the lesser of: (1) five percent of the taxpayer's gross receipts for the year from activities which might give rise to service liability; (2) a cumulative limitation equal to 15 percent of the taxpayer's average gross receipts (based on a five-year moving average) from such activities, minus any amounts already contributed to the account in prior years by the taxpayer; and (3) $100,000.

All other taxpayers would be limited to deductions equal to the lesser of: (1) two percent of the current year's gross receipts; (2) ten percent of the average receipts during the five-year base period, minus prior-year contributions; or (3) $25,000.

All distributions from the proposed service liability trust funds would be taxable when made. However, if the amounts are used by taxpayers to satisfy service liability claims, the taxpayers will be able to take an offsetting deduction. In order to discourage and penalize unauthorized distributions from trust funds (i.e., use of a trust fund for anything but service liability purposes), a ten-percent penalty tax would be added to the tax due on the amout of the distribution.

It is clearly the intention of the design community that use of the trusts established under the provisions of the proposal be limited solely to A/E firms. "Double-dipping"--taking a deduction for a liability claim/legal fee and one for a trust fund in the same year--is also not intended. Should any doubt exist that these might be permitted, we stand ready to assist in any necessary modifications of the bill or preparations of report language to cover the situations.

To insure that a liability trust fund is adequately protected, limitations are placed on use of its assets. Service liability trust fund assets may only be invested in United States securities, state or local securities, bank deposits or other investments permitted to trustees or fiduciaries under state laws. Further, the assets of a trust cannot be invested into the business of the taxpayer establishing the trust.

While the problems of the design professions and their effects on society are very important when judging the merits of the proposal, we would be remiss in not offering our best estimate of the "revenue loss" involved.

Deloitte, Haskins & Sells estimated in a Design Pofessional's Liability Study completed in July, 1980, that the total amount of federal income savings to be derived by the design professionals under the proposal's provisions for 1981 would have been $50 million. However, it is also estimated that within five years $32.8 million of this tax benefit would be recaptured as funds are used to satisfy liability claims ($25.8 million) and to pay legal expenses ($7 million). Under today's economic assumptions these figures would be even greater. These findings are based upon the two important aspects noted earlier: (1) trust usage is limited to design firms; and (2) A/E firms must use trust funds rather than other assets to meet liability needs to prevent "double-dipping" tax deductions in a given year.

While only four percent of A/E firms now use the non-deductible set-asides, two-thirds of the firms surveyed by DHS indicated that they would make some use of the design liability trust funds if Congress enacts S.2512. Fifty-eight percent of those queried reported that use of the trust fund, as permitted under S.2512, would cause them to increase their deductible amounts. Such adjustments would permit increasing policy coverages or reducing premium costs.

Design professionals are vital to all that is built for our use. They create skyscrapers, span mighty rivers, harness the power of wind, water and the sun, develop energy sources, create transportation systems, promote energy conservation and do countless other things which many take for granted. A/Es are highly qualified, technically proficient, individuals, trained through education and practical experience to develop the innovative ideas and plans that will provide a better world for all of us.

We believe that serious liability problems threaten the design professions and inhibit making maximum use of their capabilities. While we believe all efforts should be made to reform our nation's tort law, this proposal will go a long way to help solve the very real liability problems of the small businessmen and women who comprise the design professions.

It will also encourage those who would extend the state-of-the-art in architecture and engineering. In an era of growing scarcity and rising costs, the design community is the key to energy conservation, use of new materials, reduction of costs and development of better techniques.

Mr. Chairman and Members of the Subcommittee, we thank you for this opportunity to present our views on what we consider to be the most vital matter facing our nation today.

STATEMENT OF

THE

AMERICAN MOTORCYCLIST ASSOCIATION

The American Motorcyclist Association is a national non-profit membership organization of motorcycling enthusiasts with headquarters in Westerville, Ohio. Our 140,000 members are involved in all types of motorcycling activities including commuting, touring, recreational riding and competition. The AMA sanctions more than 3,000 events per year for riders. These events, while sanctioned by the Association, are conducted by more than 1,000 AMA chartered clubs. And while these sanctioned events encompass all forms of motorcycling, including tours and rallies for road riders and competition events for off-roaders, these activities share a common problem relating to an increased vulnerability to liability claims. During the past 12 months this vulnerability has left the AMA facing a liability crisis.

This crisis unfortunately brings with it a full array of associated problems including:

- Increases in liability claims from event participants.
- Increases in premium rates for event insurance coverage of more than 170 percent.
- Decreases in overall Association insurance coverage of 80 percent from $5 million to $1 million with higher coverage unavailable at any cost.
- Increases in premiums for reduced levels of coverage for blanket liability of more than 150 percent; from $22,000 to $54,000 per year.
- Lost revenue from cancelled events due to insurance cost increases of more than $20,000 in 1986 alone.
- Increases of more than $15,000 in costs associated with this crisis from unanticipated consultation and legal fees.

This liability crisis which has loomed on the horizon for some time became increasingly clear within the past 90 days as a result of astronomical increases in liability insurance premiums. These escalated premiums have left the AMA faced with its greatest threat ever to our ability to respond to the future needs and desires of our members. This threat is a direct function of our inability to adequately insure ourselves, our chartered clubs and the regional organizations which make up the AMA. This insurance is necessary to protect ourselves from unreasonable claims for liability stemming from the Association's traditional activities which have remained unchanged for more than half a century.

The primary contributor to the present crisis at the door of the AMA results from a growing increase in litigation from individuals participating in organized events. For the record it should be noted that motorsports, as with other forms of adventure recreation, brings with it some degree of risk. Traditionally participants in such events assumed the risks of their involvement in these activities. Unfortunately, however, this concept of assumption of risk has been lost before the courts in a steady deterioration of the tort law system. As a means to counter this crisis the American Motorcyclist Association has initiated a course of action to address this growing threat which includes:

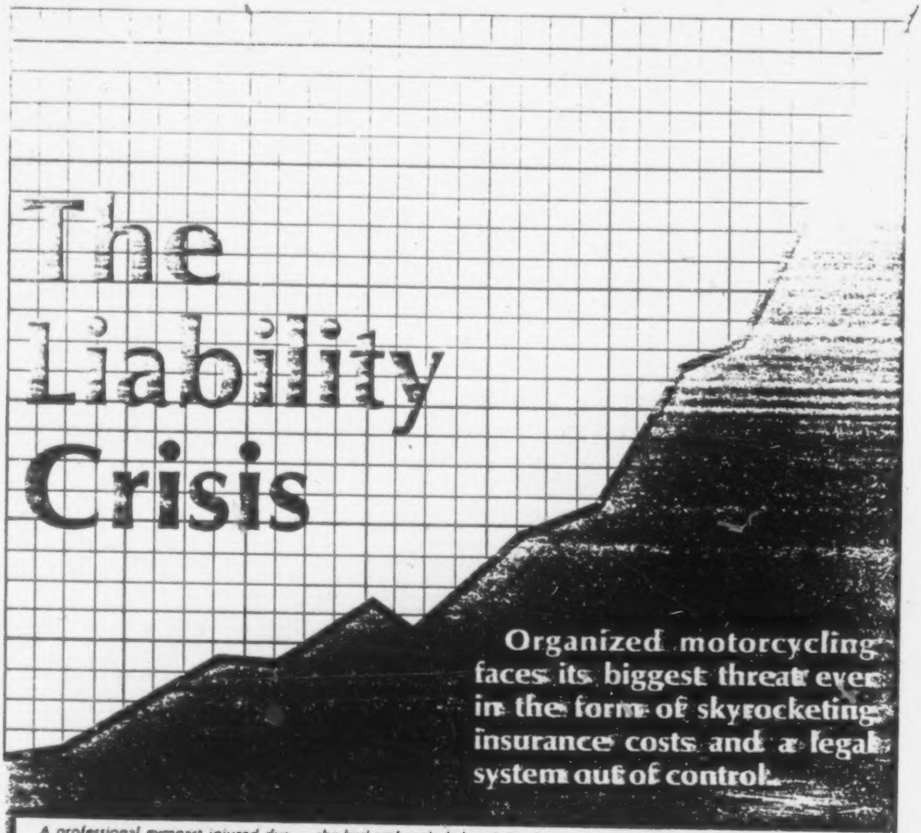
- Obtaining higher participant legal liability coverage to provided protection to the Association and its chartered clubs from the increased number of suits filed by event participants.
- Revising Association insurance requirements to provide coverage for our 40 regional organizations.
- Joining the American Tort Reform Association, a coalition of more than 100 associations and businesses interested in stopping abusive litigation and unreasonable awards for alleged damages.
- Launching a nationwide series of liability crisis workshops
- Developing a liability information kit for our chartered clubs who organize sanctioned events.
- Initiating an Association wide liability audit to identify ways in which the AMA can reduce potential liability without compromising the quantity or quality of sanctioned activities and programs

Despite all of the actions taken by the Association as a means to counter this growing concern they will surely prove inadequate if corresponding actions are not taken by congress and by state legislatures to stem the tide of this uncontrolled deterioration of the tort law system.

Tort reform is needed now! Without immediate action the AMA and countless other recreational groups may not be able to weather the storm of this pending crisis. We do not seek the sympathy of Congress; rather we urge you to take the necessary bold measures to address this liability crisis which confronts all aspects of our society.

To the extent that education of participants in risk/adventure recreation can impact the crisis, we have undertaken to make our members aware of the threat presented by the diminishing insurance availability, frivolous litigation and the need to accept some responsibility for our individual actions. Our efforts are demonstrated in the attached articles from the June and July issues of AMERICAN MOTORCYCLIST, our monthly membership publication.

While education of the public is important, we urge the committee to take positive action to bring the concrete relief needed by reforming existing tort law. We would ask your support for the broad concepts contained in S-2046, the "Litigation Abuse Reform Act of 1986," introduced by Senator Mitch McConnell.



The Liability Crisis

Organized motorcycling faces its biggest threat ever in the form of skyrocketing insurance costs and a legal system out of control.

A professional gymnast injured during a complicated flip from a trampoline sues a mat manufacturer and receives an award of $14.7 million.

A man who was seriously cut by a broken dish receives $804,000 from Corning because the company failed to warn him that the dishes might fall and shatter if stacked five deep.

A passenger on an airplane in Minnesota makes a wisecrack that the plane will crash and has to pay a fellow passenger who claims emotional distress.

A California tree trimmer charges that Hostess cupcakes gave him "toxic junk syndrome."

A Pennsylvania mother whose baby choked on peanut butter alleges that the manufacturer was at fault for not labeling the product as dangerous to infants.

A woman sues a San Jose minister for $5 million because he violated her privacy by disclosing her confession that she had embezzled church funds.

We've all heard stories like these, and you may have dismissed them as random craziness. But the fact is that such liability suits are becoming increasingly common. And plaintiffs are receiving huge amounts at an alarming rate from jury awards and insurance company settlements.

Over the past six months, the liability crisis has become a household term. It's been the subject of stories in such diverse publications as "The Wall Street Journal," "Forbes," "U.S. News and World Report" and "Sports Illustrated."

The liability crisis is hardly the kind of subject you normally see discussed in the pages of AM, nor do we enjoy tackling this topic. But as with practically every other segment of American society, organized motorcycling has become a victim of the liability crisis, bringing possible disaster and financial ruin to clubs and promoters who are not adequately prepared. Consider the following examples:

- A Michigan club with ample assets recently rented out its clubhouse for a party to an organization that had nothing to do with motorcycling. An alcohol-related auto accident after the party resulted in a suit naming the club, though it had no involvement in dispensing alcohol. Eventually, the suit against the motorcycle club was dismissed, but its insurance company canceled its liability policy. A new carrier has not yet been found and the club remains totally exposed.
- An enduro rider in Pennsylvania struck a car on a public road and was sued by the automobile owner. The motorcyclist countersued the Valley Forge Trail Riders, the East Coast Enduro Association and the AMA, alleging that they had failed to adequately provide for his safety.

Continued

AMA's response to the crisis

By October 1985 the financial state of the liability insurance industry was beginning to catch the notice of the national news media. Several precedent-setting suits against the AMA, district organizations and clubs arising in 1984 and 1985 prompted Association officials to question the adequacy of Association coverage, especially in regard to district organizations. For these two reasons, a special Insurance Advisory Committee was created within the 1986 AMA Congress.

That committee recommended a minimum of $1 million spectator legal liability and participant legal liability insurance for all sanctioned off-road events. It also recommended that those policies specifically name the district organizations among the insured parties. In the past, off-road promoters had been required to carry $100,000 in spectator liability insurance and were encouraged to purchase an equal amount of participant liability coverage.

When it came to sanctioned road events, which had not required insurance in the past, the committee encouraged organizing clubs to plan to have their events insured in the future, perhaps by 1987.

The Association staff began to work with insurance companies in an attempt to piece together coverage that would meet the recommendations of the AMA Congress. However, it soon became obvious that the task would be difficult, if not impossible. In fact, AMA officials learned that the cost of the Association's blanket liability coverage, the insurance that protects the AMA itself over and above the coverage provided by the promoter, would double in 1986 while coverages would be reduced by 80 percent. On the basis of dollar-for-dollar value, that represented a 1,000 percent increase in the premium.

At the annual meeting of corporate members in Houston on January 30, 1986, AMA President Ed Youngblood warned the trustees that the crisis could have a devastating impact on organized motorcycling. He passed along information from a January 22 meeting of leaders of nearly 100 associations where it was learned that many had their policies cancelled and found themselves unable to buy insurance at any price.

On February 14, a Friday, the Association staff finally received word from its insurance broker. The million dollar minimum coverage recommended by the AMA Congress was out of the question, since it would require a premium of $700 or more for each event sanctioned—a prohibitive cost for most clubs and promoters. Furthermore, the company providing the Association's blanket coverage said that coverage would not be available if the Association sanctioned any uninsured events, including road events. The program would go into effect April 1, allowing the AMA less than 45 days to respond and notify its clubs.

By the following Tuesday, February 18, Youngblood convened a meeting of the AMA's Finance Committee, legal counsel and insurance broker by conference call. That lengthy meeting identified a series of policy options to be reviewed by legal counsel and a series of questions to be posed to the insurance carrier. Answers were obtained over the next several days, and an emergency meeting of the trustees was convened on Tuesday, February 25, finalizing the 1986 program.

Between February 25 and March 5, less than five working days, the Association staff printed materials, completed a mailing to clubs, developed a workshop on the liability crisis and notified volunteer leaders of a special meeting in Daytona. A leadership briefing was conducted there on March 6.

That briefing was productive enough to convince the Association to take its workshop program on the road, and by the end of the first week in April, presentations were given in 15 states. While the situation remains difficult for the foreseeable future, the action taken by AMA employees, trustees and volunteer leaders has quickly spread the word to our clubs and districts about the biggest threat to motorcycling in recent times.

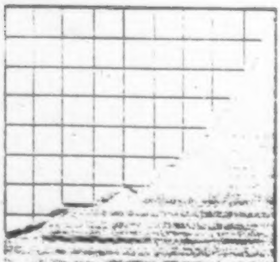
- Two motorcyclists collided on a poker run in New Jersey. The passenger of one sued her date for negligent operation, plus the Golden Arrow Motorcycle Club and the AMA for using a dangerous road. The club settled separately, but left the other defendants in the fray. The woman continued her suit against the other defendants and the AMA's insurance company settled for an undisclosed amount.
- An AMA member in Michigan entered approximately 100 amateur motocross races over a four-year period. After being injured in a spill with no other rider involved, he sued the track owner, AMA District 14 and the AMA, charging that no one had sufficiently warned him that motorcycle racing is dangerous. The insurance company for the defense settled for an undisclosed amount in spite of the fact that a subsequent informal poll of jury members showed that the case had no merit.
- An AMA member was injured in a TT race in California. He sued the Lightweight Motorcycle Club, an individual AMA official, Ascot Park and the AMA, claiming that they failed to run the race in a safe manner. He also charged that he assumed all AMA members automatically have medical insurance and that no one advised him otherwise.
- An ATV rider entered an event in Pennsylvania and collided with another participant allegedly due to a faulty throttle. He sued the ATV manufacturer, the dealer who sold the ATV, a goggles manufacturer, Rocky Ridge Riders Motorcycle Club and the AMA. The charges included sponsoring an event run by an incompetent club, failure to warn that the organizers were incompetent, failure to require inspection of the vehicle, failure to protect the plaintiff from risk and failure to warn the plaintiff that other participants were incompetent.
- A rider was "unexpectedly and violently thrown from his motorcycle" during a practice lap at a race in West Virginia. His suit does not say what threw him, but he has charged two promoters, five individuals, a track, a club and the AMA with negligently constructing a difficult course, failure to warn of extreme and outrageous danger, failure to test the course and employing incompetent race officials.
- During a Michigan ice race, a rider collided with two others. One died and the other was permanently disabled. Each received $50,000 settlements and the suits against the rider and club were dismissed. However, the plaintiffs continue their suit against the AMA and the township of Mills, Michigan.
- A rider who fell during a road tour in California sued Kern County, the State of California, the Santa Barbara Riders Association, AMA District 37, two dealerships and U.S. Suzuki. He alleges that loose gravel, other debris and sharp curves caused him to fall. He alleges that a dealer failed to properly repair his motorcycle, which caused him to fall. He also alleges that Suzuki made a motorcycle with a defective wheel and fork, which caused him to fall. The suit caused the district organization to temporarily lose its insurance.
- An 11-year-old boy was struck by a motorcycle rider at the Lake George, New York, Winter Carnival. The rider was not participating in the AMA-sanctioned race at the carnival, but was riding at a high rate of speed for his own

amusement. The rider was sued personally, but that suit was dismissed when it was determined that he had no insurance. The suit for over $500,000 in damages continues against the Lake George Chamber of Commerce, officers of the Lake George Winter Carnival, the Capitol Area Trail Riders and the AMA.

- A race fan at the DuQuoin Mile ran his motorcycle over a sleeping camper at 5 a.m. The injured party sued the rider, the campground manager, the DuQuoin State Fair Association, the promoter, the First Bank and Trust Company (because it holds a note on the fairground property), the AMA and the R. J. Reynolds Tobacco Company, simply because they sponsor the national series.
- There are two suits against the AMA pending in California resulting from events that were not even AMA-sanctioned. The plaintiffs allege that if AMA events were ever run on the track in the past, the AMA should be held responsible to warrant safety!

This is only a partial list of current litigation active against the AMA, its districts and AMA-chartered clubs. Of the nearly 30 active suits, one-third were filed by spectators while two-thirds were filed by participants, most of whom were AMA members who signed a release stating that they accepted responsibility for their own actions. Clearly, the type of liability-suit craziness affecting all of America has hit the motorcycle community as well.

The symptoms of the disease are everywhere. You can see them in insurance policy cancellations without direct cause, drastically higher insurance premiums for reduced coverage and a refusal of insurance companies to take on new risks.



The type of liability-suit craziness affecting America has hit motorcycling as well.

What has caused the liability crisis is the subject of a bitter finger-pointing debate between insurance executives and lawyers, each accusing the other of greed and short-sightedness.

The insurance industry claims that the liability crisis is the result of recent catastrophic losses and unprecedented higher awards by juries for claims that policy writers never intended to cover. Insurers point out that 1984 was the worst loss year in two decades, and that the catastrophes experienced worldwide are the worst since the 1906 San Francisco earthquake and fire. Aside from these real losses, they claim that liberal judges, creative lawyers and generous juries are saddling them with responsibilities and huge payments that were never contemplated when policies and premiums were originally structured.

Insurance companies, however, do not so readily admit to the self-serving and short-sighted business practices that contributed to the current poor insurance business climate. For example, if American courts have become a kind of lottery where injured parties can demand big awards from defendants who are actually not negligent or at fault, it's largely because insurance companies have been so prone to settle cases rather than fight. The most frivolous kind of suit today stands a better than even chance of netting a hundred-thousand dollars or more for a plaintiff and his lawyer.

While the statements by insurance companies about unprecedented and unpredictable losses may be true, their current plight is also complicated by greedy investment practices during the last decade. It is not unusual for insurance companies to pay out more in claims than they earn in premiums. Theoretically, these losses are offset by investment income, enabling insurers to

Continued

Legislative reform deemed necessary

Under the current circumstances, it is ironic that one of America's insurance giants markets its product under the slogan, "Help is on the way." It is unlikely that real help to get us out of the liability crisis will come from either the insurance industry or the legal profession. Legislative reform is required.

First, it's necessary to understand the scope of the problem. Most observers concede that the American liability insurance market has been hard hit, both by rising claims and investment losses. However, Ralph Nader and J. Robert Hunter, president of the National Insurance Consumer Organization, add a whole new wrinkle to the liability crisis.

Accusing the insurance industry of voodoo accounting, they say that losses are greatly exaggerated, and that in fact a claimed $6 billion loss in 1985 may be a $5 billion profit, including dividends.

False reporting, Hunter believes, is all part of a plan by the industry to create a false liability crisis aimed at whipping American citizens, businessmen and government officials into a frenzy against lawyers and for reform of the tort system—that part of the law dealing with liability cases.

Even if Hunter's claim is partially valid, it would be difficult to deny that the American tort system is out of control and that legislative reform is essential. Perhaps in the process controls will also be designed for the insurance industry that will eliminate the dangerous and short-sighted business practices that leave premium payers the victims of previous bad investments.

A good start may be the Litigation Reform Act of 1986, sponsored by Kentucky Sen. Mitch McConnell, with White House support. McConnell's bill would require:

- That awards of more than $100,000 be paid in installments over the lifetime of the plaintiff.
- That jury awards be reduced by offsetting payments from existing private insurance.
- That damages for pain and suffering would have a ceiling of $100,000.
- That attorneys' contingent fees could not exceed 35 percent of awards for economic losses.
- That punitive damages, the area in which some of the largest awards are made, would not be paid to plaintiffs and lawyers, but would go to the registry of the trial court, benefiting the economy and reducing the tax burden.
- That plaintiffs would have to produce evidence showing that harm resulted from willful negligence and a conscious disregard for safety.
- That court costs, fees and expenses would be imposed on any lawyer who initiated a suit merely for the purpose of wangling an out-of-court monetary settlement.

Unfortunately, McConnell's bill would apply only to federal courts. Because law is regulated on the state level, the problem of tort reform does not have one solution. It will require 50 solutions to make American courts responsible institutions. AU make profits while they offer clients bargain rates.

However, during the 1970s when interest rates were high, the insurance companies let that theory get the better of them. They cut prices in competition for the premium dollar, believing that future losses could never offset the bonanza they were making in various investment markets. They were wrong. Interest rates fell and claims grew.

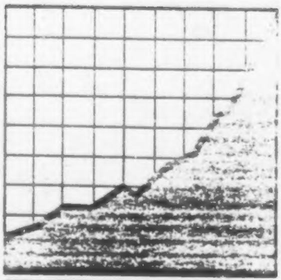
As a result, the liability industry reports it has suffered over $55 billion in underwriting losses since 1979—$21 billion in 1984 alone—that overall operations went $6 billion into the hole in 1985 and that the red ink is projected to plunge rapidly deeper for the foreseeable future. Blaming lawyers for their plight, insurers have begun to dump poor risks and increase premiums 200, 300, even 400 percent or more in an effort to get well financially.

There's no question that a hyperactive legal profession is a great contributor to the crisis as well. Today there are more than 700,000 lawyers in America, roughly one for every 400 Americans. Whereas a decade ago law was considered a conservative profession that prohibited or discouraged advertising and solicitation, today lawyers use every promotional technique imaginable to compete for business and encourage litigation. For instance, there is a lawyer in Michigan who obtains the names of motocrossers who take a spill, then calls them the following week to offer his services. In one decade product liability suits have increased from about 1,500 lawsuits per year to nearly 14,000 per year. Between 1978 and 1983, there were 12 million lawsuits filed in America, and in 1984 there was one civil action for every 15 Americans.

Attracted by ever-higher awards, lawyers are inventing and testing altogether new theories of responsibility. A Maryland court has held that handgun manufacturers can be forced to pay damages resulting from shootings. In short, direct negligence is no longer a significant factor in granting awards.

Instead of asking, "Did someone do wrong, and did it cause injury?" courts today are operating on the premise, "A person has been hurt and someone has to pay. Who has the most money to take care of this person? Who has the deepest pockets?" Deep pockets, unfortunately, will more than likely become a household term in the near future as well. It indicates the person or organization with the most assets.

Today, personal injury suits frequently have little to do with justice. Rather, the American court system has become a kind of welfare agency devoted to redistributing wealth with little regard for responsibility, fault or blame.



Deep pockets will more than likely become a household term in the near future.

With some justification, lawyers are quick to point out that they are just doing their job, dutifully serving a litigation-crazy society. And that brings us to the third major cause of the liability crisis: an American society with a radically changing sense of values when it comes to the subject of personal responsibility. Even when a person's injuries are caused by his own actions, he is apt to expect that someone else should pay.

Not too long ago organized motorcycling enjoyed a kind of family atmosphere that offered some protection from the worst abuses of liability law. Few motorcyclists would dream of suing their fellow riders or event organizers. They understood the risks and enjoyed the opportunity to participate. This atmosphere no longer prevails, and the growing file of litigation reveals several trends of which clubs and promoters must be wary.

- Suits are being filed with increasing frequency by participants. Until this year, the AMA required spectator liability insurance at racing events and recommended coverage against suits by participants. Suddenly, participants have become the dominant cause of liability litigation. Event organizers can no longer rely on an unwritten code of personal responsibility and good will among participants. Participant legal liability insurance has become essential.
- District organizations are vulnerable. Until recently, district organizations were recognized as voluntary governmental structures providing a bridge between the national organization and the local club, and they were left alone. Now, district organizations have just become one more defendant to be hit by shotgun suits aimed at everybody with the intention of finding someone with vulnerable assets. The coverage that the AMA has purchased for 1986, at

Alternative solutions to the problem

The American Motorcyclist Association has responded to the liability crisis in a variety of ways aimed at protecting the Association, its clubs and district organizations. Current actions include the following:

- Blanket liability coverage has been purchased—at double 1985 costs—that protects district organizations as named insureds.
- Tough negotiations with insurers have resulted in competition event coverages at prices lower than AMA officers expected. Coverages have been restructured to provide underlying coverage for district organizations. Coverage for road events has been obtained at less than half the cost of competition event coverage.
- An emergency "liability audit" has been undertaken to re-evaluate every aspect of the Association. By the time you read this, the Association's trustees will be considering an array of recommended techniques to reduce exposure for the AMA, its districts and chartered clubs. The study will result in new guidance materials for clubs, promoters and districts.
- A series of leadership workshops on the liability crisis have been scheduled throughout the nation.
- "The AMA Liability Information Kit" has been developed for clubs and promoters. It will be continuously updated as circumstances change.

In the area of long term solutions:

- The AMA has joined the American Tort Reform Association, a coalition of organizations and businesses devoted to stopping the abuses that are taking place on a regular basis through liability litigation.
- The government relations staff is monitoring tort reform legislation that can benefit the AMA, its clubs and its members in the long run.
- The idea of a captive insurance organization serving a coalition of motorsports organizations is under consideration.

[illegible] recognized districts as additional insureds. To complete the protection, it is essential that underlying coverages bought by event organizers also name the districts.

▸ Suits are no longer something that happen only at competition events. Suddenly, the organizers of road events have become targets for litigation. Because of the catastrophic—albeit infrequent—nature of road accidents and because several networks of lawyers have been formed to stimulate litigation by street riders, Association officials see organized road events as a critical area for coverage. Clubs that organize uninsured road events, especially if they have property and other assets, are inviting trouble. Even individuals who belong to a club could be found personally responsible. Therefore, AMA-sanctioned road events will require coverage in 1986.

The American Motorcyclist Association is searching for solutions to the liability crisis. AMA President Ed Youngblood said, "It is one of the most difficult, preoccupying, all-encompassing problems that the Association has faced. Our trustees, senior staff and many volunteer officials have had their time dominated by it in recent months. While wrestling with the short-term headaches, like where and how to get coverage at an affordable price, we've been forced to step back and rethink every aspect of the AMA in an effort to find new, creative ways to safeguard the Association, its districts, and its clubs."

What does the future hold? For the AMA and American society and business in general, most experts agree that there are no short-term solutions. Some believe that under current practices, insurance companies will become financially sound in two to three years, and that while premiums are not ever apt to return to previous low levels, perhaps insurers will be able to relax the restrictions that have made insurance unavailable, unaffordable or nearly useless for many clients.

However, no amount of premium income can offset the rampaging greed that has become possible under the current system. Plaintiffs' lawyers have demonstrated that there is no limit to the theories they will put forward, and courts have established that awards will be granted all out of proportion to the alleged damage. Discipline and responsibility will not come from within the system. Regulation and limitations must come through legislation, and this may be a slow process since our lawmaking bodies are themselves infested by lawyers.

Even if insurance industry financial ills respond to a relatively short-term solution (two to three years), and abuses within the legal system are fixed by legislation over a medium term (two to five years), the real, taproot culprit is not apt to be weeded out for a long time, if ever. Social attitudes change with generations, and we are only now beginning to feel the devastating impact of attitudes characteristic of what has been called the "me generation."

Parents who set their children loose unsupervised on ATVs and then appeal to a government agency to condemn the product; mothers who want peanut butter labeled for danger; fathers who encourage their children to race motor vehicles then sue the race organizers; and incompetent motorcyclists who fail on public roads and blame everyone but themselves are all symptomatic of a deep-seated irresponsibility and selfishness that will likely plague our society for the long term.

It's not a bright picture, but it's one that *must* change. The pendulum will swing back to center, but only after the vast majority of Americans, those who accept responsibility for their actions and who feel that enjoyment can frequently involve some form of risk, realize what is happening to society and the economy, and are willing to do something about it.

A survival plan for organizers

The liability crisis has made many clubs and organizers painfully aware of their vulnerability any time they organize an event and charge either admission or an entry fee. Because of the "deep pockets" approach to litigation, their vulnerability can be directly related to their assets.

The AMA recommends that organizers of events do the following:

- Conduct a legal review of your organization. Are your bylaws and other legal documents in order? Are you incorporated and are your individual officers shielded from liability? Do you have or can you obtain liability insurance covering the decisions and actions of your directors and officers (commonly referred to as "D and O coverage")? Are there ways to reorganize in order to protect your property and assets? Is your property insured? These are just some of the questions about which you should seek legal advice.
- Shape up your facility and improve management and maintenance. The majority of personal injury suits result from what is perceived to be inadequate fencing, poor track security or obstacles on the course. These are problems that can be overcome with a little attention and maintenance.
- Observe safety rules and use good judgment. Don't leave racetrack obstacles unprotected and don't place poker run checkpoints on the left side of the road. Do a rules review. Have your club officers review AMA rule books and discuss to what extent they are complying with basic safety rules.
- Require releases. Don't let anyone enter your event who has not signed, or for whom a parent or legal guardian has not signed, a release of liability. Set up a reliable system for cataloging and storing signed releases. They're no good to you if you can't find them later.
- Don't go uninsured. The AMA now requires insurance as a part of its sanctioning process, but even if you choose not to sanction your event, you still need insurance. If you are organizing events without liability coverage, you are inviting disaster.
- Make sure your employees or club personnel understand the problem. Keep them mindful of risk. Don't leave that hose lying out where someone can trip over it. Don't ignore the missing haybale; replace it.
- Demand discipline. If you are confronted by an uncooperative participant who wants to defy your authority or ignore the rules, refund his money immediately and eject him from the event. The kind of guy who races through the pits or continues to ride his bike around the camping area even after he has been asked to stop is exactly the kind of person who will sue you when he screws up. Get rid of him. You owe it to yourself, your insurer and your guests.
- Take a hard look at the role alcohol plays in your events. If you're looking the other way with beer in the pits, you're courting disaster. If your road runs can't draw a crowd unless there is ready access to alcohol, you should reevaluate what you're doing and who you are appealing to. More and more suits are resulting from alcohol-related accidents.
- Write to the AMA for "The AMA Liability Information Kit." Send $2 for postage and handling and list your club or promoter name and number.

ed youngblood

President

Overcoming the crisis

You're probably getting tired of reading and hearing about the liability crisis, and so are we. However, it is an issue that has been damaging to our Association, and it has the potential to do a great deal more damage. Because of that, and because we have made tremendous progress in the last 90 days, it is important to keep you up to date on the latest developments.

When the insurers of AMA events hit clubs and promoters with radically higher premiums and new requirements—such as requiring coverage for road-riding events—we were forced to put a crisis response plan into motion as quickly as possible. And as difficult as it was for the AMA, it was even worse for many of our clubs and promoters who had already publicized their events based on 1985-level entry fees.

Our plan has involved presenting as much objective information as possible and coming up with solutions to the immediate problem rather than wasting energy pointing fingers or placing blame. A lot of our findings went into a feature article that appeared in the June issue of AM. Response, measured by your calls and letters, has been strong, indicating that we got your attention and hit our mark.

We're especially pleased that we got the attention of U.S. Sen. Mitch McConnell of Kentucky, one of the leading proponents of comprehensive legal reform. McConnell thought enough of our coverage that on May 7, just a week after its publication in AM, he introduced the story in its entirety into the Congressional Record. (See page 37 of this issue for more news on legislative initiatives.)

While the AM staff was developing its message to the membership at large, a team drawn from our amateur activities, sanctioning and touring departments, together with our ATV subsidiary, developed and launched a crash series of workshops conducted for AMA clubs, promoters and district leaders all over America. During the next 60 days, five of us traveled in excess of 40,000 miles to meetings where more than 1,500 of the Association's leadership-level members discussed the immediate problem, its causes and possible short- and long-term solutions. In the typical workshop, we walked into rooms of angry, frustrated and confused club and district officers. With rare exceptions, after an hour of presentation followed by one to two hours of group discussion, this anger became channeled and focused into a determined, productive energy and a "can do" attitude based on the realization that we're all in the same mess and that it's something that we'll overcome, just as our community of motorcyclists has overcome its problems before.

It has been a gratifying, toughening, productive experience, on balance positive to all involved. In one or two areas, the local leaders have expressed great concern and predicted serious declines in AMA sanctioned motorcycle activity. Yet, thankfully, they are notable as rare exceptions, and I believe that within a short time they, too, will catch the positive spirit and determination that we have seen in one workshop after another.

We may have a long way to go in overcoming our own version of the liability crisis, but I am confident that we'll emerge as a stronger, more purposeful Association.

Indeed, there are indications of that growing strength right now. April membership reports show the largest single monthly growth in the AMA's history with a 1.2 percent overall growth—an increase of nearly 1,800 members. Those figures cap five consecutive months of growth, and place us at the threshold of 140,000 members, more than 6,000 members stronger than one year ago.

Thanks for your trust and support. We'll continue to work to earn it.

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Legislation penned for liability crisis

Over the past few months, the liability crisis has received considerable attention here in American Motorcyclist and in the national news media. Now it appears that Congress may finally be getting the message that it must take action to correct the problem, and AMA members will soon have an opportunity to help save their sport.

It now appears that Congress is taking the first steps toward a solution to the liability crisis. Several bills have been introduced at the federal level to deal with the problem and some states are also looking into legal remedies.

In the House of Representatives, three bills have been introduced which would allow the formation of so-called "risk retention groups." Such groups would be formed by banding together organizations that face similar liability problems and allowing them to purchase insurance on a group basis. The three bills are House Bill 4301, sponsored by Rep. Ron Wyden (D-Oregon), HB-4442, sponsored by Rep. Norman Lent (R-New York), and HB-4506, sponsored by Rep. John LaFalce (R-New York).

Meanwhile, in the Senate, Sen. John Danforth (R-Missouri) sponsored a bill last year that would encourage out-of-court settlements in liability lawsuits. That procedure would mean that victims would receive timely financial offers in return for settling quickly, thus avoiding costly, drawn-out court battles. Among this year's bills are Senate Bill 2129, sponsored by Sen. Robert Kasten (R-Wisconsin) and others, that would back the creation of risk retention groups, another bill by Sen. Danforth, SB-1999, that would create a uniform product liability law for all states, and SB-2038, by Sen. Mitch McConnell (R-Kentucky), that would limit damage amounts awarded for injuries and revise the rules for tort cases, that area of the law dealing with liability suits.

However, none of those bills deals with the area of punitive damages, one of the major problems to be faced in the liability crisis. Punitive damages involve a cash settlement ordered above and beyond the amount of actual damages in an effort to punish the person or organization responsible for injuries. For instance, an injured person whose actual damages from such sources as medical bills, repairs and loss of income total $25,000 can be awarded hundreds of thousands more in punitive damages under the current system.

The United States is the only nation in the world without a limit on punitive awards in liability cases. The unpredictable, and often very high, amounts that juries award in this category have been one verifiable cause of the rising liability insurance costs in recent years.

However, two bills have been introduced recently that could put a cap on the awards for punitive damages. The Reagan administration has sent to Congress a three-part legislative package that addresses this issue. That bill, SB-100, is sponsored by Sen. Kasten. It would cap non-economic damage awards, slash attorneys' fees and make it more difficult to win lawsuits against U.S. businesses.

But it is a second bill sponsored by Sen. McConnell, SB-2046, that appears to offer some of the best proposals for change in the liability situation. McConnell's proposal would cap awards for pain and suffering at $100,000, and would direct that punitive damages be paid to the court, not to the plaintiff (or the plaintiff's attorney). Economic damage awards, such as those for lost wages or medical bills, would remain the same. McConnell's bill would also limit attorneys' contingency fees on a sliding scale, from the current norm of 40 to 50 percent to a maximum of 25 percent. In addition, a penalty amounting to three times the cost of the case, plus attorney's fees, could be assessed for filing suits considered to be "frivolous." Also eliminated would be the collateral resource rule, which currently forbids the introduction of evidence by defendants regarding compensation already received by the plaintiff, meaning that juries could now know if the plaintiff has already received compensation for injuries.

legislation

An important element of the McConnell bill would bring an end to the joint and several liability rule, which has allowed lawsuits with multiple defendants and fostered the "deep pockets" approach, in which the party with the greatest ability to pay (regardless of the degree of fault) can be assessed the largest portion of a settlement—sometimes the entire amount. The concept of deep pockets is clear in a case in which a California aftermarket distributor donated prizes as part of a charity run. A participant tipped over during the run, injuring himself, and subsequently sought a party to sue. The distributor was seen as having the deepest pockets and lost tens of thousands of dollars on the case, even though he had nothing to do with the injury.

However, one area that remains at issue in McConnell's bill is the question of states' rights. The laws governing liability suits are written primarily at the state level, not in the federal Congress. Trial attorneys and, oddly enough, the insurance industry oppose federal involvement in the issue. Congress is charting new territories in considering legislation in this area, and grassroots support will be needed for passage.

The American Motorcyclist Association views McConnell's bill as a positive, comprehensive approach to a problem of immediate concern to all AMA members. We must recognize that virtually all organized activities are dependent upon the availability of liability insurance. Legislation on a state level, while commendable, would not offer the even-handed, far-reaching reform provided by McConnell's federal bill. The AMA strongly recommends that each member write to his or her senators and congressman and urge a "yes" vote for Senate Bill 2046. If you need help in getting the name and address of your representatives, contact the local branch of the League of Women Voters or write to the AMA Government Relations Department, P.O. Box 6114, Westerville, OH 43081-6114.

AMERICAN SOCIETY OF INTERNAL MEDICINE
POSITION PAPER
ON THE
PROFESSIONAL LIABILITY CRISIS

February 1986

Overview of the Problem

Medical professional liability is now as it was in the mid-1970s one of the single most important issues facing the medical community. While the crisis of 10 years ago was primarily one of "availability," physicians are now dealing with what is frequently described as a crisis of "affordability" and how it has affected access to as well as the cost and adequacy of quality medical care.

Internists and internal medicine subspecialists are being adversely affected by the crisis although not to the degree of other high risk specialties. Naturally many of the problems of the professional liability crisis are common to all physicians such as escalating professional liability premiums which add significantly to overhead expenses (in a time when many factors such as Medicare are forcing physicians to hold the line on fees) and the increasing practice of defensive medicine which adds an estimated $15 billion to the nation's overall cost of medical care.

While there are some groups such as the American Trial Lawyers Association who still question whether a crisis truly exists, the problem has been well-documented by others. According to the A. M. Best Company, independent analysts of the insurance industry, medical malpractice losses (including loss expenses incurred) have been higher than premiums earned since 1980. This loss ratio (claim losses plus loss expenses divided by premiums) was 150% in 1982 and 142% in 1983.[1] To some extent this loss as been ameliorated by investment income (interest generated by premiums until they are utilized) but even then claim losses and loss expenses have exceeded total income.

Any evaluation of how the insurance industry is performing in the medical professional liability line of business must not be limited to an examination of premiums to "paid losses" but must also include the millions of dollars spent by insurance companies in overhead, in adjusting losses, in defending physicians against claims without merit and paying company expenses and taxes.

The liability "crisis" is not limited just to medical practitioners. Rather the problem has affected a broad range of society. Skyrocketing awards have been occurring in product liability cases with their attendant costs being passed on to consumers. Some drug manufacturers have ceased producing childhood vaccines because it is virtually impossible to obtain the liability insurance necessary to stay in the market. The cost of professional liability insurance for architects and engineers is also increasing dramatically and, in some instances, the coverage is unavailable. Municipalities are having difficulty obtaining liability insurance and some are operating without it because they refuse to pay the premium that insurers are demanding or their insurers have dropped them. Further, there is evidence that many outside corporate directors are leaving their positions because their companies cannot maintain directors and officers liability insurance. If corporations maintain all-inside boards, questions obviously arise as to who is serving the shareholders.

Insurance companies are dramatically increasing rates because of their deteriorating financial position in underwriting medical professional liability insurance. Premiums vary dramatically from state to state. While average premiums for internists increased from approximately $2400 to $4400 from 1978 to 1983,[2] there are some areas of the country where annual premiums exceed $10,000.

While some argue that a few consistently negligent physicians have had a substantial impact on losses paid, the evidence shows that repeat offenders are not the problem. The fact is that most medical malpractice claims do not involve negligence. An estimated three out of four cases are ultimately settled in the provider's favor, but it is the high cost of defending claims that is also contributing to the dramatic rise in premiums.

The average physician risk of incurring a medical malpractice claim has increased nearly threefold since 1980. The incidence of claims filed against internists increased from 2.4 claims per 100 physicians prior to 1980 to 5.7 claims during the following five years.[3] An analysis of 1983 claims experienced by the 23 physician-owned medical professional liability insurance companies by the American Medical Assurance Company (AMACO), an American Medical Association subsidiary that provides reinsurance to the companies, shows that the incidence of claims has risen to 20.3 claims per 100 insured physicians. In other words, one in five physicians will be sued this year.

Claims loss severity is also increasing at an alarming rate throughout the country. Jury Verdict Research of Solon, Ohio, reports that the average medical malpractice verdict (including million dollar verdicts) in 1975 was $220,018 but by 1984 the average had risen to $666,123. In 1975 there were 3 verdicts over $1 million while in 1984 there were 71 verdicts over $1 million.

The legal system does not deal with physicians fairly. Based on a study released in 1985 by the Rand Corporation's Institute for Civil Justice, the Institute found that jurors were much more sympathetic to plaintiffs injured in medical malpractice cases than plaintiffs with the same injury that occurred on property, at work or in connection with product liability cases. Malpractice awards were as much as five times higher than injury-on-property cases.

Some experts believe that the practice of defensive medicine (the ordering of additional tests in anticipation of a medical malpractice lawsuit) may have more of an impact on health care costs than professional liability premiums. Equally, there are experts who believe that defensive medicine is simply the increased care which the malpractice system is intended to encourage and that it is not possible to distinguish defensive medicine from the overutilization that results from the economic incentives inherent in fee-for-service medicine.[4] Some defensive medicine is described as simply good medical practice. Various surveys have shown, however, that defensive medicine unquestionably is on the rise.

Indeed, surveys have shown that internists are keeping more detailed records, ordering more tests, obtaining more consultations, and are referring patients to other specialists more frequently.[5] In turn, the price of health insurance is increasing employee medical expenses thereby placing economic pressures on employers to implement cost-sharing features in their employee health benefit plans. Ultimately, the consumer of health care pays the price.

By-Products of the Problem

Although many experts believe that a good doctor-patient relationship will lead to fewer suits, the fear of a malpractice claim is causing some internists to maintain a more businesslike, "arms length" relationship with patients. No matter how good the rapport is between a patient and doctor, paranoia about malpractice and the fear of a lawsuit, especially for those who have been sued at least once, is affecting doctors' behavior around their patients.

Another area where the public as much as the provider suffers is with regard to the inefficiencies of the legal system itself. Patients who are injured because of their treatment deserve to be compensated promptly and fairly. The current legal system does not permit such a luxury because medical malpractice cases often take years to resolve. Fully one-third of all claims take more than two years to resolve, and even then, only 28 to 40 cents on the dollar (with some estimates as low as 20 to 25 cents) is returned to plaintiffs as compensation. The rest goes to attorneys and insurance companies to cover costs such as administration, claims evaluation and litigation costs.[6]

While the purpose of a lawsuit is to seek compensation for victims of malpractice and deter substandard care through the threat of legal action, there is one result that is often overlooked--the effect a lawsuit has on a physician from a personal standpoint. It has been shown that most physicians who are sued find that it is enormously disruptive to their personal and professional life. Many physicians who have been sued suffer from symptoms indicative of depression and stress which, in the long run, is likely to have an impact on the ability of the physician to deliver quality health care.[7] Medical liability lawsuits have also served as an incentive for some physicians to leave their practice or to retire at earlier ages resulting, in some cases, in the reduction in availability of care.

Tort Reform

Tort reform is not the ultimate answer to the medical malpractice problem. To the contrary, there are some tort reforms that have done little to reduce medical liability costs and others that simply have not had the effect that was originally intended. There are a few reforms, however, that when carefully drafted, can go a long ways towards reducing medical liability costs. This, in turn, would benefit patients by lowering costs and by ensuring the availability of liability insurance and, hence, availability of health care services.

Moreover, there are some states where the professional liability problem is not as serious as in others. For this reason, individual states are in the best position to determine the need for legislative relief. The following reforms are among those which have been demonstrated to provide measurable claims savings and hence a reduction in the costs of the medical malpractice system:

- Limitation on awards for non-economic damages (pain and suffering, mental anguish and loss of consortium).
- Elimination of the collateral source rule to prevent double compensation to plaintiffs. (The collateral source rule prohibits introduction of evidence of information about compensation that a plaintiff may receive from sources other than the defendant; e.g., reimbursement from a health insurance policy or workers' compensation plan for medical expenses.)
- Periodic payment of damages to eliminate windfalls to the heirs of plaintiffs who die earlier than anticipated and to more appropriately compensate patients with lifetime disabilities.
- Attorney fee regulation to ensure that reasonable compensation will go to injured plaintiffs without denying attorneys fair compensation. Earlier settlements will be encouraged (and tactics intended to delay settlements discouraged) by removing incentives to seek larger awards and therefore larger fees.
- Elimination of punitive damages from professional liability lawsuits. Punitive damages are intended to punish the wrongdoer and this responsibility should be left to the state licensing boards, medical societies, hospital peer review systems and the criminal justice system.

Standards of Care

Medical malpractice is negligent care by a health care provider that causes injury to a patient. To be awarded damages for medical malpractice, the plaintiff must prove that the legal standard of care has been breached, that there was injury and that the injury was caused by such breach. Establishing the standard of care in court is left to expert witnesses and the applicable standard is usually drawn from observation of customary practice. Eighteen states have laws establishing a medical standard of care.

One of the most difficult problems in medical malpractice cases is determining the standard of care (Should a local, state or national standard apply?). And in an era of increasingly sophisticated medical technology, when physicians cannot always agree on medical procedures, it is questionable whether a judge or lay jury can decide this issue.

Cost containment programs (Medicare's Prospective Payment System, for example) by their very nature, create pressures to restrict care which may affect its quality. Appropriate data collection and analysis should enable physicians to reach agreement on many treatment schedules (known as protocols) that would probably be helpful to some physicians who face these pressures. Any cost containment program, however, devoted to the delivery of high quality cost effective medical care should be constantly vigilant that quality of care is not compromised. A balance must be maintained in the cost-quality equation.

Peer Review/Risk Management/Disciplinary Action

State medical societies and national medical specialty societies as well as hospitals should be encouraged to implement peer review and risk management programs to ensure quality care. While there is no clear proof that risk management programs reduce the likelihood of a lawsuit, at least one medical specialty society has developed a risk management program which is believed to have been the main reason for a reduction in premiums for their particular group.

State licensing boards should be encouraged to investigate cases of medical negligence and take disciplinary action where appropriate. Insurance companies should be required to make certain data available to state agencies to aid them in their investigations. State medical examining boards often have difficulty identifying the physicians generating multiple claims involving actual negligence because claims in this category are often settled "quietly." Historically, these boards have been ineffective in revoking licenses of physicians who have demonstrated recurring aberrant practice because of, among other factors, the fear of being sued by physicians whom they seek to discipline and also because of limited resources. Efforts should be made to provide these state licensing boards with adequate resources to handle the caseload of investigations. Moreover, hospitals and state medical societies should not only report examples of flagrant and recurring negligence to state examining boards, but also patterns of care which indicate inappropriate practice or that the physician in question may be marginal.

Consumer Education/Communication

The professional liability problem is not a reflection of the quality of medical care. Rather, the evidence suggests that quality has never been higher. Publicity about medical advances, however, has raised the public's expectations about medical outcomes. Consumers have come to expect perfect results every time treatment is rendered. Consumers need to understand that physicians are human and occasionally, because of events beyond their control, either an adverse result occurs, or the patient does not experience an outcome that is 100% perfect.

Consumers also need to be fully apprised of the fact that when they hear of the million dollar verdicts, it is the consumer who ultimately pays for them. As professional liability losses escalate, so do premium dollars and ultimately, fees to patients.

In an age of rapidly increasing medical technology, specialization and impersonal medical care, doctors also need to evaluate and strengthen their relationships with their patients. More effective communication between doctor and patient would enhance these relationships.

RECOMMENDATIONS

1. ASIM supports tort reform that encourages fair compensation to all deserving injured claimants or plaintiffs and prompt resolution of professional liability claims, and all personal injury claims.

2. ASIM believes that federal intervention may be necessary because of the magnitude of the problem, but also believes that states are in the best position to judge the seriousness of the problem and to implement appropriate legislative relief.

3. ASIM supports tort reform that accomplishes the following: limits awards for non-economic damages, eliminates punitive damages, eliminates the collateral source rule, and allows for periodic payment of damages. ASIM also supports tort reform which provides for attorney fee regulation in personal injury and medical malpractice cases.

4. ASIM supports the American Medical Association position regarding the concept of data collection and analysis to "correct inappropriate variations in treatment patterns and procedures."

5. ASIM encourages physicians' active involvement in peer review activities both at the medical society level and in hospital settings.

6. ASIM supports the development of risk management programs in hospitals as well as by specialty societies and state and local medical societies.

7. ASIM supports the strengthening of state licensing boards so they can more effectively investigate cases of medical negligence and take appropriate disciplinary action.

8. The public should be educated regarding expectations about medical outcomes and the effect the medical malpractice crisis is having on the cost, availability and quality of medical care.

9. Physicians should be encouraged to strengthen doctor-patient relationships to reaffirm the doctors' position as the patients' advocate.

Definitions

Loss Expense - The cost to the insurance carrier of defending, investigating and adjusting a claim.

Reinsurance - Insurance that is purchased by insurance companies to reduce the chance of any one loss or types of losses significantly affecting a company's financial position.

Tort - The breach of a legal duty imposed by law other than by contract. A wrongful act committed by one person against another person or his or her property. Most tort claims against professionals arise from allegations of negligence or failure to exercise the required standard of care.

Tort Reform - An effort to change state laws affecting liability lawsuits.

Collateral Source Rule - The arrangement whereby a jury or a judge is not privy to other sources of payment that may be available to the plaintiff such as health insurance payments. Thus, there may be a "double award" - an award from the jury covering hospital expense and a second payment from the plaintiff's insurance company covering the same item.

ENDNOTES

[1] Professional Liability in the '80s, Report 1, American Medical Association Special Task Force on Professional Liability and Insurance, October 1984, p. 8.

[2] What Legislators Need to Know About Medical Malpractice, Robert Pierce, senior research analyst, National Conference of State Legislators, based in part on presentations made at a national conference sponsored by The Urban Institute, February 1985, in Washington, D.C., entitled "Medical Malpractice: Can the Private Sector Find Relief?"

[3] AMA Socioeconomic Monitoring System (SMS) survey, 4th Quarter, 1984.

[4] "Evaluation of the Current Malpractice System," Patricia Danzon, presentation at the Urban Institute's national medical malpractice conference, "Medical Malpractice: Can the Private Sector Find Relief?" February 21-22, 1985.

[5] "What Doctors Are Doing About The Malpractice Threat," Physician's Management, September 1985, p. 69.

[6] Danzon, February 21-22, 1985, "Medical Malpractice: Can The Private Sector Find Relief?"

[7] "Sued and Nonsued Physicians' Self-Reported Reactions to Malpractice Litigation," Sara C. Charles, MD, Jeffrey R. Wilbert, M.A., and Kevin J. Franke, M.A., American Journal of Psychiatry, 142:4, April 1985.

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"Medical Malpractice: The Employers Perspective," a report by the Washington Business Group on Health, August 1985.

STATEMENT OF THE

CHEMICAL MANUFACTURERS ASSOCIATION

I. INTRODUCTION

The Chemical Manufacturers Association (CMA) is a non-profit trade association whose members represent more than 90 percent of the productive capacity for basic industrial chemicals in the United States. Chemical industry products are shipped and used throughout the United States. Many of the chemicals manufactured by industry members are used in the workplaces of other manufacturers where they become ingredients of downstream products.

As with other industries, professionals, and state and local governments, the chemical industry is facing an insurance crisis of significant concern. We are seeing rate increases of multi-hundreds of percent, severe shrinkage of capacity so that some companies have no liability insurance at all, and self-assumed layers of insurance approaching tens of millions of dollars. Some forms of insurance have disappeared altogether, such as pollution insurance, both gradual and sudden and accidental.

This crisis finds its roots in a deteriorating business climate for insurance companies. It includes deteriorating loss ratios, declining investment income, escalating liability claims, disappearing reinsurance support, and poor business judgment by the insurance industry by engaging in "cash flow" underwriting. Add to these problems the liability provisions of the Comprehensive Environmental Response, Compensation and Liability Act (CERCLA), insurance requirements of the Resource Conservation and Recovery Act (RCRA) , changing government regulations and changing court attitudes, and varying perceptions of the chemical industry and you have a crisis expected to last well into 1987 and -- very possibly -- longer.

It should be apparent that the corporate community, including the chemical industry, cannot meet its legal responsibilities through the purchase of commercial insurance. Due to economic and legal factors which have received widespread media attention, commercial insurance either is not available or is available at a cost beyond economic feasibility.

There are few solutions from traditional insurance sources. The best avenue may be found in the several developing pooling arrangements. Unfortunately, even these arrangements fall short of providing all the coverage being demanded, nor do they defer the large price increases that are occurring.

Indigenous problems of the insurance industry are not alone in the making of this dilemma. They are only the catalyst. Indeed, the loss history for insurers continues to deteriorate especially in the "third party" insurance lines such as general, products, and automobile liability. We are all familiar with an increasing propensity to sue, social entitlement, and extension of obligations to protect health and the environment. In many cases, our financial obligations fall on the shoulders of the insurance industry. This is not new, as these concerns were recognized by the insurance industry in the mid-1970's. However, those concerns were overshadowed by an infusion of new capital from captive insurance companies, foreign insurers, and businesses in the mid-1970's that wanted to get into the financial services industry. This led to a soft insurance market for years.

Increasing demands on insurance companies, coupled with what insurers believe is an overly broad interpretation of contract language by the courts, have led to the present emotional underwriting posture of the insurance industry. The tragedy in Bhopal, India, was not the cause. It merely brought up previously overlooked underwriting risks. Add increasing litigation in general, a lack of faith in the insurance contract, poor financial results, an inability to transfer risks to someone else, and business mistakes within the insurance industry and you have today's crisis.

II. IMPACT ON THE CHEMICAL INDUSTRY

The most appropriate phrase to describe the impact on the chemical industry is probably "red lining" -- categorically refusing coverage on the basis of our industry and not on individual characteristics. Many reinsurers have indicated they will not insure certain classes of businesses and the chemical industry is one. Once the reinsurers stopped writing chemicals, primary carriers either stopped writing us altogether or severly restricted how much coverage they would offer. The potential risks of chemicals and long-term effects have created an actuarial nightmare. How can one price a risk today and get an adequate premium if one can't anticipate the impact of a worsening legal climate?

In 1985, many chemical companies saw rate increase of 200, 300, and even 400 percent. There was also a major drop in the amount of insurance that could be purchased at any price.

One of our major companies had its premium increase 300 percent last year for less than one-half the coverage. Another major company paid 400 percent more for one-fourth the coverage. Yet another of our companies had approximately $150 million in comprehensive liability coverage. In 1985, even though this company had experienced no claims in the last six years, its policy was not renewed.

In addition to the price increases, we are experiencing a loss of coverage. The insurance industry is now imposing new coverage language, known as "claims-made" policies. These policies will pay for claims the year they are presented as contrasted with "occurrence" policies which pay for losses based on the date of the incident. Most insurance buyers believe the "claims-made" policy is a major restriction in coverage.

III. POSSIBLE SOLUTIONS

A. Traditional Insurance: London Market and Other International Insurers

As far as traditional insurance is concerned, there is little if any coverage currently being written for chemical risks. In the excess market, the London market has upwards of $10-20 million in capacity at different layers, and could very well be the cornerstone of any excess insurance program. London's unique posture of writing chemical accounts, however, has created a long waiting line to see key underwriters. In addition, their new and varied policy forms raise some questions as to the acequacy and appropriateness of coverage provided.

International insurers are extremely afraid of the U.S. court system. Therefore, they have not rushed into the U.S. market to fill the void and are not expected to in the foreseeable future.

B. Traditional Insurance - U.S. Markets

As far as U.S. insurance companies are concerned, perhaps a half dozen still insure chemicals. Others consider chemicals if they also write primary coverage or have other unique considerations. Additionally, the forms, underlying limit requirements, premiums, and inability to add new business this underwriting year are all subjects of concern and consequently insurance may be unavailable for any particular risk.

C. Self-Insurance

Self-insurance is an alternative. As an alternative to insurance, self-insurance could be the least attractive option because of an inability to take tax deductions for losses until they are paid. Also, how much should be set aside to budget for losses is of major concern.

Self-insurance opens up new areas of financial concerns, including instability of operating results and earnings, stockholder dissatisfaction, and debt capacity concerns. The costs of internal claims administration, including impact on accounting, legal, claims control and loss control are all issues to be considered. However, many choose self-insurance because of better control of claims, good control of cash flow and other perceived benefits.

D. Pooling, Captives, and Joint Venture Insurance Alternatives

Of great value, though long-term with respect to a capability to solve the insurance crisis, is pooling with other companies and captives. There are currently several companies who have banded together to look into setting up captives or pooling arrangements. However, these groups provide coverage at a catastrophic level - usually $50-$100 million - which mid-size and small companies cannot meet.

IV. CMA ACTIVITIES IN RESPONSE TO THE INSURANCE CRISIS

CMA has taken a number of steps to help our companies address the insurance crisis. These steps include participation in product liability reform efforts, service on an advisory committee exploring the environmental liability insurance problem and creation of a new CMA committee to collect and share information on insurance matters. Following is a discussion of these areas.

A. Product Liability

CMA has been an active participant in recent product liability reform efforts. These reform efforts have resulted from a continuing expansion of industry's exposure to product liability judgments. This expansion has gone so far that the courts are clogged, reasonable casualty insurance is unavailable and a business can be unjustly ruined by liability without fault or causation, punitive damages and class actions.

Product liability has emerged as a costly impediment to interstate commerce. Uncertainties and imbalance in the product liability tort litigation system will continue in the absence of a uniform statute enacted at the Federal level.

CMA believes product liability reform is needed and overdue. Throughout our participation in reform efforts, CMA has sought to preserve and perfect the traditional fault based product liability tort law system as a fair means of compensating those who have suffered wrongful injury. At the same time, CMA has strongly opposed liability without fault, and particularly liability without causation, whether in the tort law system or some other liability scheme.

B. NAIC Advisory Committee on Environmental Liability Insurance

The National Association of Insurance Commissioners (NAIC) is conducting a study of the issues relating to environmental liability insurance. To assist in the study effort, an Advisory Committee has been formed consisting primarily of representatives from insurance companies and their trade associations. CMA is one of two industrial groups represented.

The Advisory Committee's goal is to address the criteria for a viable insurance market. CMA hopes to be of assistance in gathering information on the impact of the proposed recommendations, and to work with the Committee to ensure a balanced final report.

C. Special Committee on Insurance

In response to our members' concerns regarding the current insurance situation, CMA has formed a Special Committee on Insurance. This Committee will provide a forum within the chemical industry for the collection and sharing of information on insurance matters and for exploring options for resolving the unavailability of insurance.

V. RECOMMENDATIONS FOR CONGRESSIONAL REVIEW

CMA believes that Congress must address the insurance crisis. To help alleviate this crisis, we propose the following recommendations for Congressional review.

A. Reform of the Nation's Product Liability Laws

The present product liability system is breaking down under the weight of excessive litigation, exorbitant legal fees and unreasonable damage awards. The expansion of product liability has gone so far that reasonable casualty insurance is unavailable.

It is time for Congress to reform our product liability laws. A fair and balanced uniform product liability law would help bring our runaway liability system under control.

Such a bill should include a fault-based standard for judging the adequacy of product design and the appropriateness of safety warnings. It should provide a clear presumption that a product meeting government safety requirements is reasonably safe. It should adopt the principle of comparative responsibility so that damages reflect the extent to which plaintiffs contributed to their own injuries. And it should limit punitive damage awards, which in recent years have become subject to jury abuse. We believe these changes would make a significant improvement in the current product liability system and would improve the outlook for insurance.

B. Tax Deductibility of Self-Insured Reserves

Since commercial insurance either is not available to the corporate community or is available only at a prohibitive cost, companies must explore other options to cover their legal obligations. To help companies meet this challenge, Congress should facilitate the use of these other options.

One important option is self-insurance. As mentioned earlier, however, this option is limited because of an inability to take tax deductions for losses until they are paid.

We urge Congress to reform the Tax Code to permit corporations who elect to self-insure, either through a captive insurer or through reserves for expected losses, to deduct these reserves. A self-insurance reserve would almost always be less than the cost of commercial insurance, due to the reduced costs of overhead, profit, commissions and taking into account current insurance premiums. Therefore, allowing a corporation to deduct its self-insured reserves should result in lower costs to the corporation and increased revenues to the government. As reserves of the corporate self-insured, as they are actuarially established, and the commercial insurer serve the same purpose and are subject to the same claim liability, there is no rational reason for differentiating between them for tax purposes.

C. Review Uninsurable Liabilities in Existing Laws

Recent federal environmental legislation has changed many of the basic principles of tort law. CERCLA in particular departs from these traditional tort principles, imposing virtually absolute retroactive liability upon parties whose actions may have been completely lawful at the time they were taken. Moreover, courts have almost uniformly upheld the government's position that CERCLA permits imposition of joint and several liability when the damages are indivisible. Thus complete recovery may be had from any one of the responsible parties.

Industry and its insurers could not foresee the novel principles of liability deriving from CERCLA and similar legislation. Under some circumstances, CERCLA may make liability a virtual certainty. This has led insurers to believe that environmental risk is uninsurable.

Congress should carefully study any new legislation to make sure that the liabilities being imposed are insurable. Further, it should carefully review existing legislation with a view toward creating insurable liabilities.

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March 12, 1986

Mr. Joseph K. Dowley
Chief Counsel
Oversight Subcommittee
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, D.C. 20515

Dear Mr. Dowley:

I am writing and submitting comments on behalf of the Coalition of Automotive Associations (CAA), to be included as part of the record of the hearings scheduled to be held by this Committee on March 13 and 17, 1986, concerning the cost and availability of liability insurance. CAA is a trade association comprised of over 2,100 small businesses which manufacture and distribute aftermarket parts and accessories for motor vehicles.

It is an undisputable fact that there is a current problem in the marketplace in finding affordable liability insurance - if such insurance still exists. The problem has quickly evolved into a crisis which is affecting numerous industries and professions. Unfortunately, small businesses seem to have been hit the hardest. Over the past two years, many of our members have found that product liability insurance, at any price, was wholly unavailable to them and they have been forced to continue in business without the insurance protection which is essential to provide for the reasonable recovery of legitimate consumer claims. Still more of our members have found that the levels of insurance available to them have decreased from $10 million, to $5 million, to $1 million, and now, $300,000 in aggregate claims. Even though insurance is available to them, the levels are such as to render the insurance essentially meaningless. For those who are offered coverage in amounts approaching $300,000, the premiums have increased to $25,000 to $50,000 per year where they had been previously averaging $2,000 to $5,000 per year for $5 million in product liability coverage. The remaining few of our members who have been successful in retaining reasonable limits of liability coverage have experienced increases in premiums of 300 to 1,000 percent.

It appears that there are several factors which have contributed to the current situation, such as the descent from high interest rates of recent years, the withdrawal of national re-insurance groups outside of the United States, and the general litigious character of American society. While it is not precisely clear how to remedy the situation, it is obvious that something has to be done. The impact on the business community has been devastating. Companies have been driven out of business, prices of consumer products have sharply increased and injured consumers with legitimate claims are frequently finding that those who might be liable have no capability of compensating them for their losses due to their limited assets and lack of insurance coverage.

A part of the solution for dealing with this exploding crisis is to provide a tort liability system which has more predictability and certainty than what currently exists. Historically, obtaining liability insurance was a relatively simple task since liability claims could be accurately projected based on past experience, which provided a predictable basis upon which to establish premiums. This was capable of being done because it was known that the standard for liability would be based on negligence. Although negligence was defined by state law, and there obviously were some differences among the various state laws, the rules for defining what would constitute negligence and the consequences of that negligence were reasonably ascertainable in a given state. Within the last couple of decades, however, there have been creative new theories under which compensation has been awarded to injured plaintiffs. Courts today appear to be placing more emphasis on the relative ability of plaintiff and defendant to absorb the consequences of defendant's activity than on the defendant's culpability. This is apparent with the increased use of the doctrine of strict liability. This evolution of the tort system was accompanied by a dramatic increase in litigation, including large awards for punitive damages and for non-economic losses. CAA strongly supports the action taken by the members of the Senate Committee on Commerce, Science and Transportation in the area of product liability reform. Their proposed uniform federal product liability law will hopefully restore the predictability and certainty of tort liability to allow small business to once again obtain affordable and adequate insurance coverage. We request that members of this Committee support similar legislation which may be proposed in the House.

We applaud this Committee for addressing the problem of the cost and availability of liability insurance and request that the members take action to effectively remedy the situation. We appreciate having the opportunity to comment and look forward to Committee action addressing the serious problem which has arisen in the insurance market and detrimentally effected the entire business community.

Sincerely,

John Russell Deane

JOHN RUSSELL DEANE III

JRD/sdg

COUNCIL OF MEDICAL SPECIALTY SOCIETIES
P.O. Box 70 Lake Forest, Illinois 60045 • (312) 295-3456

April 18, 1986

The Honorable Dan Rostenkowski
U.S. House of Representatives
Washington, DC 20515

Dear Congressman Rostenkowski:

Citizens in every part of the United States are gravely concerned about the increasing cost of liability insurance and the constraints the loss of insurance protection is placing upon their lives. The member societies of the Council of Medical Specialty Societies (CMSS) realize that the liability insurance crisis is a complex problem which is not susceptible to simple nor to rapid solutions and that there are at present a variety of suggested remedies before Congress. CMSS representatives have identified eight principles of tort reform rather than just supporting one or several of these proposed bills. Enactment of any combination of them would be of considerable benefit in alleviating the current crisis. Enactment of all of them would be a giant step toward a more equitable system of recompense for injured persons.

The proposed reforms in outline form and by title only are:

1) Total cap on non-economic losses
2) Elimination of the collateral source rule
3) Establishment of a sliding scale for contingency fees
4) Periodic payments
5) Elimination of punitive damage awards
6) Elimination of joint and several liability
7) Shortened statute of limitations (especially minors)
8) Credentialing of expert witnesses

The twenty medical societies, representing over 170,000 physicians, who have signed their names to this letter urge your support for these principles which, when enacted, will help to resolve equitably the present problems facing all citizens including physicians. The CMSS and/or any of the twenty societies will be happy to discuss with your staff the rationale for and a more complete explanation of any or all of the above summarized principles.

Sincerely,

John S. Strauss, M.D., President
Council of Medical Specialty Societies

cc: Supporting Medical Specialty Societies
CMSS Representatives

COUNCIL OF MEDICAL SPECIALTY SOCIETIES
P.O. Box 70, Lake Forest, Illinois 60045 • (312) 295-3456

NATIONAL SPECIALTY SOCIETIES SUPPORTING THE CMSS EIGHT PRINCIPLES OF TORT REFORM

American Academy of Allergy and Immunology

American Academy of Dermatology

American Academy of Neurology

American Academy of Ophthalmology

American Academy of Orthopaedic Surgeons

American Academy of Otolaryngology -- Head & Neck Surgery

American Academy of Pediatrics

American Academy of Physical Medicine and Rehabilitation

American Association of Neurological Surgeons

American College of Emergency Physicians

American College of Obstetricians and Gynecologists

American College of Radiology

American Psychiatric Association

American Society of Anesthesiologists

American Society of Colon and Rectal Surgeons

American Society of Plastic and Reconstructive Surgeons

American Urological Association

College of American Pathologists

Society of Nuclear Medicine

Society of Thoracic Surgeons

A Preliminary Examination of Available Civil and Criminal Trend Data in State Trial Courts for 1978, 1981, and 1984

Produced by:
Court Statistics and Information Management Project
National Center for State Courts
300 Newport Avenue
Williamsburg, VA. 23187-8798

April 1986

NOTE: The following tables are excerpts from a larger volume to be published later this Spring 1986 called, State Court Caseload Statistics: Annual Report, 1984.

NEWS RELEASE

National Center for State Courts • 300 Newport Avenue • Williamsburg, Virginia 23187-8798

For release: 6:00 p.m.
Monday, April 21, 1986.

Contact: Robert T. Roper
(804) 253-2000

Study reveals no
litigation explosion
in state courts

WILLIAMSBURG, VA--"Careful examination of current available trial court data relating to tort, contract, real property rights and small claims cases, from a representative group of state courts, provides no evidence to support the existence of a national 'ligitation explosion' in state trial courts during the 1981-84 time period," according to Dr. Robert Roper, director of the Court Statistics and Information Management (CSIM) project of the National Center for State Courts.

Twenty states, which include 29 limited and general jurisdiction statewide court systems, reported reliable and comparable tort, contract, and real property rights statistics on the number of lawsuits filed for the years 1978, 1981, and 1984. The data revealed a 14 percent increase in filings for 1978-81, and a 4 percent decrease in 1981-84.

Small claims suits might best measure the inclination of Americans to sue because of easy accessibility, relatively inexpensive cost, and prospects for a quick resolution. Twenty-nine limited and general jurisdiction statewide court systems in 25 states were chosen for analysis due to their reliable and comparable small claims statistics. Small claims filings increased 18 percent in 1978-81. but decreased 6 percent in 1981-84.

-MORE-

In the area of torts alone, which is a subset of civil filings, total filings increased slightly in both the 1978-81 and the 1981-84 periods. However, all of the three states that reported significant increases during 1981-84 also reported the largest increases in population (Alaska, California, and Hawaii). During 1981-84, tort filings increased 7 percent while population increased 4 percent. For the entire period 1978-84, total tort filings increased 9 percent, but the population also increased by 8 percent.

The data provide a basis for the following observations:

- An upward trend in litigation in any one period is not necessarily attributable to an increase in the tendency of the average American to sue, but may indicate a simple increase in the number of average Americans.
- There may have been significant increases in civil filings which peaked around 1981; however, civil filings (defined as tort, contract and real property right cases) decreased slightly during the 1981-84 period. In fact, in state courts that reported data for the 1981-84 time periods, there were decreases in the total number of civil filings.

According to Dr. Roper, several reasons could account for the downward trend in litigation. Insurance companies and attorneys may increasingly find it in their interest to settle conflicts before the cases ever reach the courts. Also, people may be deterred from filing suits at all because of widespread reports about the cost of litigation, and the prospect of civil suits taking years before disposition.

-MORE-

The often cited litigation explosion thus appears to be exaggerated with respect to the total number of civil filings during the period of 1981-84. The source of the perception that there is a litigation explosion may be founded in a changing mix of civil cases, increased complexity of the cases being filed, and widespread media reports of enormous awards in relatively few civil cases.

Complete supporting data will be available later this spring from the Williamsburg-based National Center for State Courts, in a volume entitled "State Court Caseload Statistics, 1984."

* * * * *

Published annually since 1975 (with the exception of 1982 and 1983) the state court caseload statistics series was developed by the Center's CSIM project in cooperation with the Conference of State Court Administrators. Work on the 1984 volume was completely funded by the National Center for State Courts; however, previous work on this project was funded by the Bureau of Justice Statistics. These reports are designed to collect, compile, analyze, and disseminate comparable state court caseload statistics; they are based on data provided by the state court administrators' offices and the offices of the state appellate court clerks. The series presents a methodology for reporting caseload statistics, nationwide current caseloads, as well as trends useful in future court planning.

-MORE-

The National Center's basic mission is to help courts better serve both litigants and the general public. Courts at all levels are involved in one or more of the Center's projects, which range from research aimed at reducing delay in the litigation process to work conducted by the Center's regional offices on such subjects as automation of court operations and personnel administration. Emphasis is given to the training of court managers and presiding judges through the National Center's Institute for Court Management. In addition, the National Center serves as a clearinghouse for information on state courts. Besides its headquarters in Williamsburg, the Center maintains offices in North Andover, Mass., San Francisco, Denver, Arlington, Va., and Washington, D.C.

4/14/86-rtr

Part II. Trends

Questions about the "litigation explosion" in the state trial courts are among those most frequently received by CSIM Project staff. Part II of this *1984 Annual Report* is a preliminary effort to shed some light on the question, "Is there a 'litigation explosion' in the state trial courts?"

Dates chosen for trend data.

The years 1981 and 1984 were chosen as two of the data points for these tables because the *State Trial Court Jurisdiction Guide for Statistical Reporting* was first applied to the 1981 trial court data, and the 1984 data is the most recent available. Since those two years represent a three-year interval, an earlier three-year interval was needed to bring balance to the trend line. Therefore, the first point chosen was 1978.

Case types selected for analysis.

When talking of a "litigation explosion," most people reference an increased propensity, in the mindset of individuals, to sue for damages and punitive awards. Some of the CSIM case types that address this issue are tort, contract, and real property rights cases. In addition, small claims procedures are easily accessible, relatively inexpensive to file in and work within, and provide a comparatively speedier disposition of justice, and therefore, are a more interesting measure of the public's propensity to litigate.

Additionally, these case categories were chosen because they have, over the years, been reported separately, by many courts, without having any other minor case types included in their totals. The same is not true of other case categories, such as domestic relations, where subcategories are often reported with juvenile cases, miscellaneous, or special civil proceedings.

Criminal cases do not reflect on the "litigation explosion" as it is defined above, however, felonies are included in these trend data to provide a more complete picture of the courts' workloads over time.

The first table presents the general picture by displaying data for the combined category of tort, contract, and real property rights cases. This table is followed by a table for small claims. The final two civil tables break down the general table into one for tort, and one for contract cases. There were insufficient data, over the seven year period to justify compilation of a table for real property rights cases. The final table evaluates trend data for felony cases.

Population as an indicator of caseload changes.

Earlier volumes in this *Annual Report* series have documented that the single best predictor of civil filings in state courts is the total state population. Total population explained over 90% of the variance in civil filings among the state courts. Therefore, the percentage increase in state population has been included in these tables for all three time periods--1978-1981, 1981-1984, and 1978-1984 in order to explain, at the outset, what kind of case filing increases might be anticipated as a result of changes in the state populations.

At this point, it is not possible to accurately predict what percentage increase in filings one would expect for every percent increase in the population. Therefore, for purposes of this *Report*, a rough one to one relationship has been assumed, i.e., for every percent increase in population, a one percent increase in filings would be expected.

Courts included in the tables

Some state courts do not appear in these tables for a variety of reasons: they do not report statewide data at all, they do not provide sufficient detail to identify the case types reported in these tables, they have changed reporting categories over time, and finally, the jurisdiction and organization of some courts have changed so dramatically between 1978-84 that their data were not comparable. Therefore, the courts displayed on the following tables do not include complete nationwide data; however, they are representative of general jurisdiction courts in this country, and are adequate for addressing the issue of whether there is a litigation explosion. For example, Table 33, on small claims, has statewide data from 33 states from across all geographical regions, and from large and small states. Although Tables 32 and 34-36 do not have as much complete state data as does Table 33, the data are more often than not from general jurisidiction courts. Since these are the courts most likely to hear the serious cases, these courts complement the small claims data found in Table 33.

Summary statistics presented on the facesheets.

Three summary measures. Each of Tables 32-36 display the number of filings for the years 1978, 1981 and 1984, and the percent changes in total state populations and filings for each of the three time periods 1978-81, 1981-84 and 1978-84. The accompanying facesheet for each table summarizes the data presented in each table using the following three measures: (1) the aggregate data contained in the table for those courts that reported complete data for each of the three years; (2) a summary description of how many courts experienced increased or decreased filings for the two periods 1978-1981 and 1981-1984; and (3) a chart which identifies patterns of change, and specifically lists the courts within each pattern.

Patterns across time, the "up-up" and "up-down" patterns. There are two basic patterns that can be used to test crudely whether there continues to be a "litigation explosion." The first group represents those courts whose filings increased during the 1978-81 period, and continued to rise during the 1981-84 period (i.e., and "up-up" pattern). This "up-up" pattern alone, however, does not represent prima facie evidence of a "litigation explosion." This "up-up" category must be separated into three components: (3-a) courts whose upward increases in both time periods were at approximately the same rate of increase and whose increases significantly exceeded the rate of increases in the total population; (3-b) courts whose filings increased, during 1981-84, at a rate significantly less than the rate they were increasing at during 1978-81--which indicates a slowing of any upward trend that might have occured during earlier years; and (3-c) courts whose filings increased significantly during the period 1978-81, but whose filings increased at a rate which approximated or was less than the rate at which the population increased during 1981-84. The last component (i.e., 3-c), represents courts where there is not a "litigation explosion," because filings did not increase at a rate equal to or significantly different from population increases. Therefore, the only "up-up" pattern which may indicate unusual increases in filings is a "3-a"--where court filings increased significantly over both periods.

The second major group of courts, which run counter to the "up-up" pattern, are those courts which exhibited significant increases in filings during 1978-81, but whose filings actually decreased during the 1981-84 period (i.e., an "up-down" pattern). Courts that fall into this category are clearly "over the hump," and no longer experiencing increases in the number of civil suits.

Other miscellaneous patterns appear sporadically throughout the tables. These can clearly be identified as either supportive, or not supportive of the claim to a "litigation explosion." For example, some courts may not have experienced any significant change in filings for both time periods. On the other hand, filings in some courts went down during the 1978-81 period, and have increased significantly during the latter period. These situations will be discussed as they occur in each of the tables.

Limitations on the data

The data presented on the following tables are the most accurate, reliable, and comprehensive data yet brought to bear on the question of whether there is a "litigation explosion" in the state courts. This is a preliminary look at the topic, however, and the reader should consider the following caveats when evaluating the analysis--none of which are thought to affect general conclusions that can be drawn from these tables: although the data are representative from all the states, they do not include all of the courts and states in the country; due to limited resources, Project staff were unable to complete the trend table for the missing years or identify all jurisdictional changes in those courts over time; the data are only as current as 1984 and changes may have occured during 1985; the data do not include many other civil case types which may have included different trends during that time period (e.g., divorce, support/custody, adoption, estate, civil appeals, and miscellaneous civil cases); and the findings are restricted to the state courts only.

General findings and explanations

A careful examination of available data relating to tort, contract, real property rights, and small claims cases from a representative group of state courts provides no evidence to support the often cited existence of a national "litigation explosion" in the state trial courts during the 1981-84 time period.

There are some state courts that have experienced significant increases in the case types described throughout this section, but the impact of that finding is reduced when one realizes that these are the courts in states that have also experienced significant increases in their total populations. Changes in the number of these filings are not attributable to an increase in the propensity of the average American to sue, but rather to a simple increase in the numbers of average Americans.

The findings, however, can be extended one further step. Not only is the evidence missing to indicate a significant national increase in filings above the increase in population, but a clear pattern emerges which generally supports the "up-down" model described earlier. In a significant number of state courts, selected civil filings have decreased between the period 1981-1984 (see the individual tables for specific details).

It may be that there was a litigation explosion that peaked around 1981. The evidence from these charts tends to support that observation. There were significant increases in filings between 1978-81, far exceeding the increases in population. In fact, the increases were so large during 1978-81, that despite the decreases that occurred during 1981-84, the percentage changes from 1978-84 are still showing moderate increases.

The often cited myth of a continuing upward trend of civil lawsuits in the state courts could result from several factors: (1) intensive media focus on the enormous size of the awards in a few selected and well publicized civil cases; and (2) increased workload in the courts, not caused by an increase in the rate of civil lawsuits, but by more complex cases, and perhaps fewer resources available to the courts to handle expected increases in filings which results in larger backlogs.

Additionally, there are a variety of potential explanations for the leveling off or decreases in civil suits: (1) The public's attitude toward lawsuits may be changing. People may be deterred from filing as a result of concerns about costs and civil litigation that is likely to take years--except for the more serious cases, it may not be worth the effort; (2) For years people speculated that greater numbers of laws resulted in increased litigation to interpret those laws--this testing of new legislation and judicial rules may have run its course; and (3) Finally, insurance companies and attorneys may be increasing their efficiency in settling conflict before cases reach the courts. Whatever the explanation, there is no evidence to support the notion of a nationwide increase in lawsuits in the state trial courts between 1981-84.

TABLE 32: Trend data for state courts that specifically reported tort, contract, and real property rights case filings for 1978, 1981, and 1984.

Courts included in this table.

For inclusion in this table, a court must have reported an identifiable tort, contract, and real property rights caseload, separate from all other civil cases, in at least two of the three target years. Five states reported tort, contract, and real property rights cases for all the courts which had jurisdiction over tort, contract and real property rights cases in those states. A total of 37 statewide courts, in 25 states, reported data. Of the 37 courts, 12 were general jurisdiction courts.

Comparison of aggregated filings over time.

The following data are from the 29 courts in 20 states that reported comparable data for all three reporting years. These figures can be found on the bottom line of Table 32.

The increase in tort, contract, and real property rights filings between 1978-81 was 14%, while the population for the states reporting these data increased by 3%. Between 1981-84, the population continued to grow another 3%, but the new filings decreased by 4%. These aggregate figures provide preliminary evidence for the existence of the "up-down" pattern discussed earlier in this section.

Comparison of courts whose filings increased or decreased during each of the time periods.

The following chart displays the number of courts whose tort, contract, and real property rights filings have increased or decreased during the two time periods:

	1978-81	1981-84
Filings increased significantly more than the population:	19	7
No significant difference between the change in population and filings:	5	3
Filings did not increase measureably during this period:	0	3
Filings increased at a rate slower than the population:	0	2
Filings decreased during this period:	5	22
Comparable data were not available for the period:	8	0

The "up-down" pattern described in the introduction to this section is illustrated in the above chart. Most of the courts reporting tort, contract, and real property rights cases during 1978-81 experienced significant increases in their filings. During the 1981-84 period, however, the pattern reversed itself--the majority of courts reported decreases in filings of these case types. Less than twenty-five percent of the courts reporting tort, contract, and real property rights cases during 1981-84 experienced increases in their filings at a rate significantly higher than increases in their populations. These patterns are more firmly established in the following chart.

The chart above displays how all of the courts which reported data during either of the two periods fit into specific categories. The following chart links the filing patterns of specific courts across the two time periods to test, more specifically, the various patterns identified earlier.

Comparison of patterns among the courts.

The following chart expands on the previous one by listing and categorizing courts by the patterns they followed. These patterns are explained in the introduction to this section (i.e., Part II). These are the patterns for those 29 courts in 20 states that reported comparable data for all three years. The (G) or (L) after each court indicates whether it is a general or limited jurisdiction court:

1. "Up-up" Pattern (no caveats):	Civil Court of NYC (L)
2. "Down-up" Pattern (no caveats):	Alaska Superior Court (G) New Mexico Magistrate Court (L) Oregon Justice Court (L)
3. "Up-up" Pattern (change in '81-'84 filings was less than '78-'81 increase in filings):	Nebraska County Court (L)
4. "Up-up" Pattern (change in '81-'84 population exceeds or approximates change in '81-'84 filings):	Hawaii Circuit Court (G) Hawaii District Court (L) Delaware Justice of the Peace (L)
5. "Up-no significant change":	Delaware Court of Common Pleas (L)
6. "No significant change - no significant change":	Delaware Superior Court (G)
7. "Up-down" Pattern:	Alabama Distrct Court (G) Arkansas Chancery and Probate Court (G) Colorado District Court (G) Colorado County Court (L) Indiana County Court (L) Indiana Municipal Court of Marion County (L) Kentucky District Court (L) Maine District Court (L) North Carolina Superior Court (G) North Carolina District Court (L) Ohio Municipal Court (L) Ohio County Court (L)

TABLE 32: Trend data for state courts that specifically reported tort, contract, and real property rights case filings for 1978, 1981, and 1984. (continued)

	Pennsylvania District Justice Court (L)
	Tennessee Circuit Court and Chancery (L)
8. "No significant change-down":	Oregon District Court (L)
	Rhode Island District Court (L)
	Washington Superior Court (G)
9. "Down-down" Pattern:	District of Columbia Superior Court (G)
	Colorado Water Court (G)

Of the courts studied in Table 32, the Civil Court of New York City is the only court whose filings have continued to increase significantly more than the population over the two time periods studied in this *Report*. Three additional courts followed the "down-up" pattern with significant increases reported during 1981-84. Another four courts experienced increases in filings between 1981-84, but the increases were either less than or not significantly different from population increases during that same time period, or the increases were less than the increases reported during the 1978-81 period. The remaining 18 courts showed no evidence of a "litigation explosion" during 1981-84, and 17 of those courts experienced a decrease in filings during that period.

TABLE 32: Trend data for state courts that specifically reported tort, contract, and real property rights case filings for 1978, 1981, and 1984.

		Filings			Percent change 1978-1981		Percent change 1981-1984		Percent change 1978-1984	
State and court title	Juris-diction	1978	1981	1984	Popu-lation	Filings	Popu-lation	Filings	Popu-lation	Filings
COMPLETE STATE DATA:										
Exclusive court jurisdiction:										
District of Columbia:										
Superior Court	G	121,931	108,426	96,975	-6%	-11%	-1%	-11%	-7%	-20%
Kansas:										
District Court	G	NC	54,005	57,140	--	--	2%	6%	--	--
Not exclusive court jurisdiction:										
Colorado (STATE TOTAL)		79,480	105,028	99,206	7%	32%	7%	-6%	14%	25%
District Court	G	22,561	36,168	32,032	7%	60%	7%	-12%	14%	42%
Water Court	G	2,868	2,321	1,688	7%	-19%	7%	-23%	14%	-41%
County Court	L	54,051	66,539	66,485	7%	23%	7%	-2%	14%	21%
Hawaii (STATE TOTAL)		12,204[1]	17,379[1]	17,960[1]	6%	42%[1]	6%	3%[1]	12%	47%[1]
Circuit Court	G	2,786[1]	3,830[1]	3,992[1]	6%	37%[1]	6%	4%[1]	12%	43%[1]
District Court	L	9,418	13,549	13,968	6%	44%	6%	3%	12%	48%
North Carolina:		54,738	65,856	58,118	4%	20%	4%	-12%	7%	6%
Superior Court	G	11,541	13,756	12,482	4%	19%	4%	-9%	7%	8%
District Court	L	43,197	52,100	45,636	4%	21%	4%	-12%	7%	6%
INCOMPLETE STATE DATA:										
Alabama:										
District Court	L	40,130	55,818	51,805	2%	39%	2%	-7%	4%	29%
Alaska:										
Superior Court	G	2,683	2,312	3,107	3%	-14%	21%	34%	25%	16%
Arkansas:										
Chancery and Probate Court	G	6,642	7,545	5,151	2%	14%	2%	-32%	5%	-22%
Delaware:										
Superior Court	G	2,457	2,522	2,520	0%	3%	3%	0%	3%	3%
Court of Common Pleas	L	2,898	3,740	3,755	0%	29%	3%	0%	3%	30%
Justice of the Peace .	L	15,844	20,028	20,806	0%	26%	3%	4%	3%	31%
Indiana:										
Municipal Court Marion County	L	8,901	14,364	10,131	0%	61%	1%	-29%	1%	14%
County Court	L	3,550[1]	5,573[1]	3,664[1]	0%	57%[1]	1%	-34%[1]	1%	3%[1]
Kentucky:										
District Court	L	48,808	57,627	56,359	1%	18%	2%	-2%	3%	15%
Maine:										
District Court	L	17,751[1]	20,072	16,146	2%	13%[1]	2%	-20%	4%	-9%[1]
Minnesota:										
County Court	L	NC	28,014	21,582	--	--	2%	-23%	--	--
Montana:										
District Court	G	NC	7,764	6,492	--	--	4%	-16%	--	--
Nebraska:										
County Court	L	9,236	11,128	13,027	1%	20%	2%	17%	3%	41%
Municipal Court	L	NC	17,781	17,712	--	--	2%	0%	--	--
New Hampshire:										
District Court	L	NC	10,382	9,815	--	--	4%	-5%	--	--
New Mexico:										
Magistrate Court	L	14,276	14,117	18,308	6%	-1%	7%	30%	14%	28%
Bernalillo County Metropolitan Court ..	L	NC	8,290	9,744	--	--	7%	18%	--	--
New York:										
Civil Court of New York City	L	130,131	151,159	195,163	-1%	16%	1%	29%	0%	50%
Court of Claims	L	NC	1,330	1,678	--	--	1%	26%	--	--
Ohio:										
Municipal Court	L	241,951[1]	260,068[1]	221,523[1]	0%	7%[1]	0%	-15%[1]	0%	-8%[1]
County Court	L	5,854[1]	11,302[1]	9,542[1]	0%	93%[1]	0%	-16%[1]	0%	63%[1]

TABLE 32: Trend data for state courts that specifically reported tort, contract, and real property rights case filings for 1978, 1981, and 1984. (continued)

State and court title	Jurisdiction	Filings			Percent change 1978-1981		Percent change 1981-1984		Percent change 1978-1984	
		1978	1981	1984	Population	Filings	Population	Filings	Population	Filings
INCOMPLETE STATE DATA (continued):										
Oregon:										
District Court	L	31,600	33,862	24,518	6%	7%	1%	-28%	7%	-22%
Justice Court	L	1,102[f]	942[f]	1,336[f]	6%	-15%[f]	1%	42%[f]	7%	21%[f]
Pennsylvania:										
District Justice Court	L	163,556	188,199[d]	183,143	0%	15%	0%	-3%[d]	0%	12%
Rhode Island:										
District Court	L	22,394	23,689	18,759	0%	6%	1%	-21%	1%	-16%
Tennessee:										
Circuit Court and Chancery Court	G	20,561	23,442	21,506	3%	14%	2%	-8%	6%	5%
Texas:										
District Court	G	NC	68,451	85,873	--	--	8%	25%	--	--
Washington:										
Superior Court	G	32,029	34,922	33,140	9%	9%	3%	-5%	12%	3%
Totals for 29 courts in 20 states reporting comparable data for all three years		1,090,707	1,239,120	1,185,666	3%	14%	3%	-4%	5%	9%

G = General jurisdiction court
L = Limited jurisdiction court
NC = Data are not comparable with other years.
d = The number of dispositions was the only data element provided that year.
-- = Data element is not applicable.

[f] Data are not complete:
Hawaii-Circuit Court--Data do not include "unreported cases."
Indiana--County Court--Data do not include "other" cases or "redocketed civil" cases.
Maine--District Court--Due to implementation of a new reporting system, data are missing from two locations.
Maryland--Circuit Court--Data do not include "unreported cases."
Ohio--Municipal Court and County Court--Data do not include cases classified as miscellaneous civil.
Oregon--Justice Court--Not all courts reported data.

TABLE 33: Trend data for state courts that specifically reported small claims case filings for 1978, 1981, and 1984.

Courts included in this table:
For inclusion in this table, a court must have reported an identifiable small claims caseload, separate from all other civil cases, in at least two of the three targeted years. Twenty-nine states reported small claims cases for all the courts which had jurisdiction over small claims cases in those states. A total of 39 statewide courts, in 33 states, reported data. Of the 39 courts, 11 were general jurisdiction courts.

Comparison of aggregated filings over time:
The following data are from the 29 courts, in 25 states, that reported comparable data for all three reporting years. These figures can be found on the bottom line of Table 33.

The increase in small claims filings between 1978-81 was 18%, as the population for that same period rose only 2%. The period between 1981-84 again provides a different picture. During this second period, the population continued to increase at a rate of 2% for those states reporting these data, yet small claims filings decreased by 6%. These aggregate figures tend to support the "up-down" pattern discussed in the introduction to this section.

Comparison of courts whose filings increased or decreased during each of the time periods.
The following chart displays the number of courts whose small claims filings have increased or decreased during the two time periods:

	1978-81	1981-84
Filings increased significantly more than the population:	21	6
No significant difference between the changes in population and filings:	6	10
Filings did not increase measureably during this period:	0	1
Filings increased at a rate slower than the population:	0	1
Filings decreased during this period:	3	19
Comparable data were not available for the period:	9	2

During the period 1978-81, the majority of courts experienced significant increases in small claims filings; however, that pattern was reversed during the following three years when most of the courts reporting data experienced decreases in small claims filings. Small claims data fit the "up-down" pattern described in the introduction to this section of the Annual Report.

The chart above displays how all of the courts which reported data during either of the two periods fit into specific categories. The following chart links the filing patterns of specific courts across the two time periods to test, more explicitly, the various patterns identified earlier.

Comparison of patterns among the courts.
The following chart expands on the previous one by listing and categorizing courts by the patterns they follow. These are the patterns for those 29 courts, in 25 states, that reported comparable data for all three years:

1. "Up-up" Pattern (no caveats):	North Dakota County Court (L) Rhode Island District Court (L)
2. "No significant change-up":	New Jersey Superior Court (G)
3. "Up-up" Pattern: (change in '81-'84 filings was less than '78-'81 increase in filings):	Colorado County Court (L) Hawaii District Court (L) Illinois Circuit Court (G) Maine District Court (L) Missouri Circuit Court (G) Vermont District Court (L)
4. "Up-up" Pattern (change in '81-'84 population exceeds or approximates change in '81-'84 filings):	Alaska District Court (L) New Hampshire District Court (L)
5. "Down-up" Pattern (Change in '81-'84 population exceeds or approximates change in '81-'84 filings):	District of Columbia Superior Court (G) New York District Court and City Court (L)
6. "No significant change - No significant change"	Idaho District Court (L) Ohio Municipal Court (L)
7. "Up-down" Pattern:	California Municipal Court (L) Indiana Superior Court and Circuit Court (G) Indiana County Court (L) Kansas District Court (G) Kentucky District Court (L) Nebraska County Court (L) New Hampshire Municipal Court (L) North Carolina District Court (L) Ohio County Court (L)

TABLE 33: Trend data for state courts that specifically reported small claims case filings for 1978, 1981, and 1984. (continued)

Oregon District Court (L)
Pennsylvania-Philadelphia Municipal Court (L)

8. "No significant change-down":
    California Justice Court (L)
    Iowa District Court (G)

9. "Down-down" Pattern:
    Alabama District Court (L)

Only two courts had significant and continuous increases in small claims filings during both 1978-81 and 1981-84. In addition, the New Jersey Superior Court experienced a significant increase during 1981-84. Ten other courts also reported increases in their small claims filings, but the increases were either significantly less than the earlier increase during 1978-81, or were less than or approximated the population change for that same period which would indicate no "litigation explosion" at all. Eleven courts fit the "up-down" pattern, and another three courts also experienced decreases in small claims filings during 1981-84.

TABLE 33: Trend data for state courts that specifically reported small claims case filings for 1978, 1981, and 1984.

State and court title	Juris-diction	Filings 1978	Filings 1981	Filings 1984	Percent change 1978-1981 Population	Percent change 1978-1981 Filings	Percent change 1981-1984 Population	Percent change 1981-1984 Filings	Percent change 1978-1984 Population	Percent change 1978-1984 Filings
COMPLETE STATE DATA:										
Exclusive court jurisdiction:										
Alabama:										
District Court	L	95,928	91,550	76,694	2%	-5%	2%	-16%	4%	-20%
Alaska:										
District Court	L	7,948[1]	10,143[1]	10,735[1]	3%	28%[1]	21%	6%[1]	25%	35%[1]
Colorado:										
County Court	L	10,294	13,683	16,460	7%	33%	7%	20%	14%	60%
Connecticut:										
Superior Court	G	NC	90,447	73,096	--	--	1%	-19%	--	--
District of Columbia:										
Superior Court	G	32,797	24,490	25,323	-6%	-25%	-1%	3%	-7%	-23%
Florida:										
County Court	L	NC	172,208	163,171	--	--	8%	-5%	--	--
Hawaii:										
District Court	L	1,313	3,355	5,388	6%	156%	6%	61%	12%	310%
Idaho:										
District Court	L	13,504	14,217	14,174	5%	5%	4%	0%	10%	5%
Illinois:										
Circuit Court	G	175,454	205,055	217,641	0%	17%	0%	6%	1%	24%
Iowa:										
District Court	G	72,064	75,258	71,664	-1%	4%	0%	-5%	0%	-1%
Kansas:										
District Court	G	10,670	14,707	14,229	2%	38%	2%	-3%	5%	33%
Kentucky:										
District Court	L	27,585	34,550	28,525	1%	25%	2%	-17%	3%	3%
Maine:										
District Court	L	14,350	21,063	22,718	2%	47%	2%	8%	4%	58%
Minnesota:										
County Court	L	NC	99,420	90,271	--	--	2%	-9%	--	--
Missouri:										
Circuit Court	G	11,745	16,110	19,106	1%	37%	1%	19%	3%	63%
New Jersey:										
Superior Court	G	40,535	42,012	51,137	1%	4%	1%	22%	2%	26%
North Carolina:										
District Court	L	171,612	226,604	194,321	4%	32%	4%	-14%	7%	13%
North Dakota:										
County Court	L	5,396	6,446	8,523	1%	19%	4%	32%	5%	58%
Oklahoma:										
District Court	G	77,798	NC	85,181	--	--	--	--	13%	9%
Pennsylvania:										
Philadelphia Municipal Court	L	26,043	29,328	26,253	0%	13%	0%	-10%	0%	1%
Rhode Island:										
District Court	L	6,802	8,383	12,087	0%	23%	1%	44%	1%	78%
South Dakota:										
Circuit Court	G	NC	17,999	19,259	--	--	4%	7%	--	--
Vermont:										
District Court	L	6,252	7,978	8,952	4%	28%	3%	12%	6%	43%
Washington:										
District Court	L	21,456	26,706	NC	9%	24%	--	--	--	--
Wisconsin:										
Circuit Court	G	NC	173,220	168,563	--	--	1%	-3%	--	--
Not exclusive court jurisdiction:										
California (STATE TOTAL)		453,662	561,908	512,804	6%	24%	6%	-9%	12%	13%
Justice Court	L	32,128	35,477	30,225	6%	10%	6%	-15%	12%	-6%
Municipal Court	L	421,534	526,431	482,579	6%	25%	6%	-8%	12%	14%

TABLE 33: Trend data for state courts that specifically reported small claims case filings for 1978, 1981, and 1984. (continued)

State and court title	Juris-diction	Filings 1978	Filings 1981	Filings 1984	Percent change 1978-1981 Popu-lation	Percent change 1978-1981 Filings	Percent change 1981-1984 Popu-lation	Percent change 1981-1984 Filings	Percent change 1978-1984 Popu-lation	Percent change 1978-1984 Filings
Indiana: (STATE TOTAL)		NC	172,013[1]	156,705[1]	--	--	1%	-9%[1]	--	--
Superior Court and Circuit Court	G	29,682[1]	44,593[1]	35,042[1]	0%	50%[1]	1%	-21%[1]	1%	18%[1]
Small Claims Court of Marion County	L	NC	49,899	54,380	--	--	1%	9%	--	--
County Court	L	66,011[1]	77,521[1]	67,283[1]	0%	17%[1]	1%	-13%[1]	1%	2%[1]
New Hampshire (STATE TOTAL)		22,816	28,246	29,513	5%	24%	4%	4%	9%	29%
District Court	L	22,114	27,408	28,993	5%	24%	4%	6%	9%	31%
Municipal Court	L	702	838	520	5%	19%	4%	-38%	9%	-26%
Ohio (STATE TOTAL)		90,615	94,324	93,817	0%	4%	0%	-1%	0%	4%
Municipal Court	L	77,671	80,254	82,155	0%	3%	0%	2%	0%	6%
County Court	L	12,944	14,070	11,662	0%	9%	0%	-1%	0%	-10%
INCOMPLETE STATE DATA:										
Nebraska:										
County Court	L	10,033	12,561	11,613	1%	25%	2%	-8%	3%	15%
New York:										
Civil Court of NYC	L	NC	59,728	52,065	--	--	1%	-15%	--	--
District Court and City Court	L	44,176	43,822	47,887	-1%	-1%	1%	9%	0%	8%
Oregon:										
District Court	L	43,422	54,457	37,548	5%	25%	1%	-31%	7%	-14%
Utah:										
Circuit Court	L	NC	27,888	31,467	--	--	9%	13%	--	--
Totals for 29 courts in 25 states reporting comparable data for all three years:		1,490,699	1,762,364	1,659,439	2%	18%	2%	-6%	4%	11%

G = General jurisdiction court
L = Limited jurisdiction court
NC = Data are not comparable with other years
-- = Data element is not applicable

[1] Data are incomplete:
Alaska--District Court--Data do not include cases from low volume courts.
Indiana--Superior Court and Circuit Court, County Court--Data do not include cases classified as "other."

TABLE 34: Trend data for state courts that specifically reported tort case filings for 1978, 1981, and 1984.

Courts included in this table:

For inclusion in this table, a court must have reported an identifiable tort caseload, separate from all other civil cases, in at least two of the three targeted years. Five states reported tort filings for all the courts which had jurisdiction over torts in those states. A total of 21 statewide courts, in 17 states, reported data. Of the 21 courts, 17 were general jurisdiction courts.

Comparison of aggregated filings over time:

The following data are from the 17 courts in 13 states that reported comparable data for all three reporting years. These figures can be found on the bottom line of Table 34.

The increase in tort case filings between 1978-81 was only 2%, while the population for those states grew 4% during the same time period. Between 1981-84 the population grew another 4% while tort filings increased by 7%. For the entire period 1978-84 total tort filings increased 9%, however, the population also increased by 8%. This is the one case type, of those studied in this section, where the aggregate number of cases increased over both time periods evaluated. This does not qualify as a "litigation explosion", however, since the population increased at approximately the same rate as did the tort filings.

Comparison of courts whose filings increased or decreased during each of the time periods.

The following chart displays the number of courts whose tort filings have increased or decreased during the two time periods:

	1978-81	1981-84
Filings increased significantly more than the population:	8	5
No significant difference between the changes in population and filings:	5	5
Filings increased at a rate slower than the population:	1	1
Filings decreased during this period:	5	8
Comparable data were not available for the period:	2	2

Although the aggregate filings increased somewhat over the years studied in Table 34, the above chart indicates that tort filings increased significantly in less than half of the courts reporting data in this table. During the period 1981-84, only one-third of the courts reporting data had a significant increase in tort filings--more courts experienced decreases than significant increases in tort filings during 1981-84. The chart above displays how all of the courts which reported data during either of the two periods fit into specific categories. The following chart links the filing patterns of specific courts across the two time periods, to test more explicitedly, the various patterns identified earlier.

Comparison of patterns among the courts.

The following chart expands on the previous chart by listing and categorizing courts by the patterns they followed. These patterns are explained in the introduction to this section (i.e., Part II). These are the patterns for those 17 courts that reported comparable data for all three years. The (G) and (L) after each court indicates whether it is a general or limited jurisdiction court.

1.	"Down-up" Pattern (no caveats):	Alaska Superior Court (G) California Superior Court (G) Florida Circuit Court (G)
2.	"Up-up" Pattern: (change in '81-'84) filings was less then '78-'81 increase in filings):	Hawaii Circuit Court (G) Washington Superior Court (G)
3.	"Up-up" Pattern (change in '81-'84 population exceeds or approximates change in '81-'84 filings):	Alaska District Court (L)
4.	"Down-up" Pattern (Change in '81-'84 population exceeds or approximates change in '81-'84 filings):	North Dakota District Court (G)
5.	"No significant change - no significant change"	Ohio Court of Common Pleas (G) Maine Superior Court (G)
6.	"Up-down" Pattern:	Colorado District Court (G) Hawaii District Court (L) Kansas District Court (G) New York Supreme Court and County Court (G) Ohio County Court (L) Ohio Municipal Court (L) Tennessee Circuit Court and Chancery Court (G)
7.	"No significant change-down":	Idaho District Court (G)

Of the courts reporting comparable data for all three years, none experienced significant increases during both 1978-81 and 1981-84. Three additional courts reported decreases during the first period but significant increases in the 1981-84 period. These three courts, however, are in states that also experienced some of the

TABLE 34: Trend data for state courts that specifically reported tort case filings for 1978, 1981, and 1984. (continued)

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largest increases in population (i.e., Alaska, California, and Hawaii).

The largest numerical increase in tort filings between 1981-84 is in the California Superior Court (i.e., an increase of over 16,000 cases). This increase, almost single handedly, accounts for the entire increase in the aggregate figures between 1981-84. Between the years 1978-84 however, the increase in the rate of filings was 12%, but was matched by a 12% increase in the population.

In addition to the fact that most states which have large increases in filings also have the largest increases in population, and therefore do not qualify as being especially litigious, another eight courts reported decreases in filings, and two other state courts reported no significant change in their filings over both periods studied. Although tort filings do not fit the "up-down" pattern as strongly as do other case types, neither do they provide any evidence of an increased propensity of the American public to sue.

TABLE 34: Trend data for state courts that specifically reported tort case filings for 1978, 1981, and 1984.

State and court title	Juris-diction	Filings			Percent change 1978-1981		Percent change 1981-1984		Percent change 1978-1984	
		1978	1981	1984	Popu-lation	Filings	Popu-lation	Filings	Popu-lation	Filings
COMPLETE STATE DATA:										
Exclusive court jurisdiction:										
Kansas--District Court ..	G	3,249	4,517	4,033	2%	39%	2%	-11%	5%	24%
Idaho--District Court ...	G	1,728[1]	1,744[1]	1,729[1]	5%	1%[1]	4%	-1%[1]	10%	0%[1]
Not exclusive court jurisdiction:										
Alaska (STATE TOTAL)		1,356[1]	1,428[1]	1,885[1]	3%	6%[1]	21%	31%[1]	25%	39%[1]
Superior Court	G	921	886	1,305	3%	-4%	21%	47%	25%	42%
District Court	L	435[1]	552[1]	580[1]	3%	27%[1]	21%	5%[1]	25%	33%[1]
Hawaii (STATE TOTAL)		2,032[1]	2,505[1]	2,304[1]	6%	23%[1]	6%	-8%[1]	12%	13%[1]
Circuit Court	G	1,155[1]	1,468[1]	1,611[1]	6%	27%[1]	6%	10%[1]	12%	39%[1]
District Court	L	877	1,037	693	6%	18%	6%	-33%	12%	-21%
Ohio (STATE TOTAL)		39,645	41,603	36,171	0%	5%	0%	-13%	0%	-9%
Court of Common Pleas	G	21,587	21,906	22,149	0%	1%	0%	1%	0%	3%
County Court	L	127	705	519	0%	455%	0%	-26%	0%	309%
Municipal Court	L	17,931	18,992	13,503	0%	6%	0%	-29%	0%	-25%
INCOMPLETE STATE DATA:										
California:										
Superior Court	G	86,729	80,970	97,068	6%	-7%	6%	20%	12%	12%
Colorado:										
District Court and Denver Superior Court	G	3,481	5,089	4,199	7%	46%	7%	-17%	14%	21%
Florida:										
Circuit Court	G	21,761[1]	21,063[1]	26,815[1]	12%	-3%[1]	8%	27%[1]	20%	23%[1]
Maine:										
Superior Court	G	1,803	1,914	2,083	2%	6%	2%	9%	4%	16%
Maryland:										
Circuit Court	G	7,902[1]	8,135[1]	NC	1%	3%[1]	--	--	--	--
Montana:										
District Court	G	NC	1,465	1,519	--	--	4%	4%	--	--
New York:										
Supreme Court and County Court	G	35,684	39,234	37,847	-1%	10%	1%	-4%	0%	6%
North Dakota:										
District Court	G	732	516	550	1%	-30%	4%	7%	5%	-25%
Tennessee:										
Circuit Court, Chancery Court (Law and Equity Court in 1978 and 1981)	G	10,457	12,046	11,775	3%	15%	2%	-2%	6%	13%
Texas:										
District Court	G	NC	28,698	34,224	--	--	8%	19%	--	--
Utah:										
District Court	G	872	775	NC	11%	-11%	--	--	--	--
Washington:										
Superior Court	G	6,882	7,919	8,997	9%	15%	3%	14%	12%	31%
Totals for 17 courts in 13 states reporting comparable data for all three years		215,539	220,558	235,456	4%	2%	4%	7%	8%	9%

G = General jurisdiction court
L = Limited jurisdiction court
NC = Data are not comparable with other years
-- = Data elements are inapplicable

[1] Data are incomplete:
Alaska--District Court--Data do not include low volume courts.
Florida--Circuit Court--Data do not include professional tort cases.
Hawaii--Circuit Court--Some tort cases are included in transfers.
Idaho--District Court--Some torts are included in the unclassified category.
Maryland--Circuit Court--Data do not include "unreported cases."

TABLE 35: Trend data for state courts that specifically reported contract case filings for 1978, 1981, and 1984.

Courts included in this table:
For inclusion in this table, a court must have reported an identifiable contract caseload, separate from all other civil cases, in at least two of the three targeted years. Two of the states reported contract filings for all the courts which had jurisdiction over contract cases in those states . A total of 15 statewide courts, in 13 states, reported data. Of the 15 courts, 11 were general jurisdiction courts.

Comparison of aggregated filings over time:
The following data are from the 11 courts in 10 states that reported comparable data for all three reporting years. These figures can he found on the bottom line of Table 35.

The increase in contract case filings between 1978-81 was 14%, while the population for those states grew 5% during the same period. Between 1981-84, the population grew another 4%, however, new contract filings decreased by 15%--a clear reversal in the earlier trend of caseload expansion. For the entire period 1978-84, total contract filings decreased 4% while the population increased 9%. These aggregate data support the "up-down" pattern for contract filings.

Comparison of courts whose filings increased or decreased during each of the time periods.
The following chart displays the number of courts whose contract filings have increased or decreased during the two time periods:

	1978-81	1981-84
Filings increased significantly more than the population:	7	2
No significant difference between change in population and filings:	1	1
Filings increased at a rate slower than the population:	1	2
Filings decreased during this period:	2	10
Comparable data were not available for the period:	4	0

Once again, the "up-down" pattern materializes. Most of the courts studied during the 1978-81 period experienced significant increases in filings, while this trend reversed itself during the period 1981-84 when most courts experienced decreases in their filings of contract cases. The Florida Circuit Court and the Texas District Court were the two courts that experienced signifcant increases in their case filings, yet they also recorded the largest increases in population for those courts that reported data during 1981-84. The chart above displays how all of the courts which reported data during either of the two periods fit into specific categories. The following chart links the filing patterns of specific courts across the two time periods to test, more specifically, the various patterns identified earlier.

Comparison of patterns among the courts.
The following chart expands on the previous one by listing and categorizing courts by the patterns they followed. These patterns are explained in the introduction to this section (i.e., Part II). These are the patterns for those 11 courts that reported comparable data for all three years. The (G) or (L) after each court indicates whether it is a general or limited jurisdiction court:

1. "Up-up" Pattern (no caveats):	Florida Circuit Court (G)
2. "Up-up" Pattern (change in '81-'84 population exceeds or approximates change in '81-'84 filings):	Hawaii Circuit Court (G) Hawaii District Court (L)
3. "Up-down" Pattern:	Colorado District Court (G) Maine Superior Court (G) North Dakota District Court (G) Ohio County Court (L) Ohio Municipal Court (L) Tennessee Circuit Court and Chancery Court (G)
4. "Down-down" Pattern:	Arkansas Court of Common Pleas (L) Washington Superior Court (G)

The Florida Circuit Court is the only court that can lay claim to a large increase in contract filings. Courts in 8 other states followed the down trend after 1981.

TABLE 35: Trend data for state courts that specifically reported contract case filings for 1978, 1981, and 1984.

State and court title	Juris-diction	Filings 1978	Filings 1981	Filings 1984	Percent change 1978-1981 Popu-lation	Percent change 1978-1981 Filings	Percent change 1981-1984 Popu-lation	Percent change 1981-1984 Filings	Percent change 1978-1984 Popu-lation	Percent change 1978-1984 Filings
COMPLETE STATE DATA:										
Exclusive court jurisdiction:										
Kansas:										
District Court	G	NC	39,175	41,982	--	--	2%	7%	--	--
Not exclusive court jurisdiction:										
Hawaii (STATE TOTAL)		9,175[1]	13,460[1]	14,055[1]	6%	47%[1]	6%	4%[1]	12%	53%[1]
Circuit Court	G	1,434[1]	2,047[1]	2,131[1]	6%	43%[1]	6%	4%[1]	12%	49%[1]
District Court	L	7,741	11,413	11,924	6%	47%	6%	4%	12%	54%
INCOMPLETE STATE DATA:										
Arkansas:										
Court of Common Pleas	L	377[1]	300	102	2%	-20%[1]	2%	-66%	5%	-73%[1]
Colorado:										
District Court	G	14,147	22,395	15,270	7%	58%	7%	-32%	14%	8%
Florida:										
Circuit Court	G	27,005	29,677	38,650	12%	10%	8%	30%	20%	43%
Maine:										
Superior Court	G	1,318	1,456	1,103	2%	10%	2%	-24%	4%	16%
Maryland:										
Circuit Court	G	NC	6,576[1]	5,496[1]	--	--	2%	-16%[1]	--	--
Montana:										
District Court	G	NC	5,860	4,420	--	--	4%	-25%	--	--
North Dakota:										
District Court	G	3,095	4,412	4,062	1%	43%	4%	-8%	5%	31%
Ohio:										
Municipal Court	L	171,166[1]	187,657[1]	149,332[1]	0%	10%[1]	0%	-20%[1]	0%	-13%[1]
County Court	L	3,648[1]	7,749[1]	5,740[1]	0%	112%[1]	0%	-26%[1]	0%	57%[1]
Tennessee:										
Circuit Court, and Chancery Court	G	7,327	8,830	7,582	3%	21%	2%	-14%	6%	3%
Texas:										
District Court	G	NC	38,902	51,152	--	--	8%	31%	--	--
Washington:										
Superior Court	G	21,679	18,748	13,891	9%	-14%	3%	-26%	12%	-36%
Totals for 11 courts in 10 states reporting comparable data for all three years		258,937	294,684	249,787	5%	14%	3%	-15%	9%	-4%

G = General jurisdiction court
L = Limited jurisdiction court
NC = Data are not comparable with other years.
-- = Data elements are inapplicable.

[1] Data are incomplete:
Arkansas--Court of Common Pleas--One county reported no data in 1978.
Hawaii--Circuit Cou[illegible]--S[illegible] cases are included in trans[illegible]
Maryland--Circuit Court--Data do not include some "unreported cases."
Ohio--Municipal Court and County Court--Some contract cases are included in miscellaneous civil cases.

TABLE 36: Trend data for state courts that specifically reported triable felony case filings for 1978, 1981, and 1984.

Courts included in this table:

For inclusion in this table, a court must have reported an identifiable triable felony caseload, separate from all other criminal cases, in at least two of the three targeted years. A total of 28 statewide courts in 28 states reported data. All of these courts are general jurisdiction courts.

Comparison of aggregated filings over time:

The following data are from the 24 courts in 24 states that reported comparable data for all three reporting years. These figures can be found on the bottom line of Table 36.

The increase in triable felony cases between 1978-81 was 28%, while the population for the states reporting these data increased by 3%. Between 1981-84, the population continued to grow another 3%, and new triable felony filings increased by 7%. The pattern for these aggregate filings evidence a considerable slowing of the filing pattern during 1981-84. In fact, during the 1981-84 period, triable felony case filings did not increase at a rate significantly greater than the rate at which the population increased.

Comparison of courts whose filings increased or decreased during each of the time periods.

The following chart displays the number of courts whose triable felony filings have increased or decreased during the two time periods:

	1978-81	1981-84
Filings increased significantly more than the population:	22	8
No significant difference between the changes in population and filings:	0	6
Filings did not increase measurably during this period:	0	1
Filings increased at a rate slower than the population:	0	2
Filings decreased during this period:	2	11
Comparable data were not available for the period:	4	0

Approximately three-fourths of these courts reporting triable felony filings between 1978-81 experienced significant increases in their caseloads. This tendency for increased filings, however, was greatly diminished during 1981-84 when almost twice as many courts reported decreases in their felony filings as courts who reported filing increases significantly greater than population increases. This observation is more clearly illustrated in the following chart.

The chart above displays how all of the courts which reported data during either of the two periods fit into specific categories. The following chart links the filing patterns of specific courts across the two time periods to test, more specifically, the various patterns identified earlier.

Comparison of patterns among the courts.

The following chart expands on the previous one by listing and categorizing courts by the patterns they follow. These patterns are explained in the introduction to this section (i.e., Part II). These are the patterns for those 24 courts in 24 states that reported comparable data for all three years.

---

1. "Up-up" Pattern (no caveats):
   - Alaska Superior Court
   - District of Columbia Superior Court
   - New Jersey Superior Court
2. "Down-up" Pattern (no caveats):
   - Minnesota District Court
3. "Up-up" Pattern: (change in '81-'84 filings was less than '78-'81 increase in filings):
   - Arkansas Circuit Court
   - Hawaii Circuit Court
   - Illinois Circuit Court
   - New York Supreme Court and County Court
4. "Up-up" Pattern (change in '81-'84 population exceeds or approximates change in '81-'84 filings):
   - Arizona Superior Court
   - California Superior Court
   - Colorado District Court
   - Idaho District Court
   - North Dakota District Court
   - Virginia Circuit Court
   - Washington Superior Court
5. "Up-down" Pattern:
   - Georgia Superior Court
   - Kansas District Court
   - Maine Superior Court
   - North Carolina Superior Court
   - Ohio Court of Common Pleas
   - Oregon Circuit Court
   - Rhode Island Superior Court
   - Wyoming District Court
6. "Down-down" Pattern:
   - Wisconsin Circuit Court

Of the 24 statewide courts reporting data in Table 36, only four experienced increases in filings that continued to increase significantly more than the population. The number of triable felony filings decreased during the period 1981-84 in nine of the statewide courts reported

TABLE 36: Trend data for state courts that specifically reported triable felony case filings for 1978, 1981, and 1984. (continued)

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in this table. As is the case with torts, it appears as though the rate of increases in felony filings has decreased. Additionally, downward trends were experienced in a large number of statewide courts. This trend in felony cases, may be a function of changes in a variety of variables ranging from: the actual crime rate, the rate of reported crime, the police clearance rate, state criminal law, and prosecuting rates.

TABLE 36: Trend data for state courts that specifically reported triable felony case filings for 1978, 1981, and 1984.

State and court title	Filings			Percent change 1978-1981		Percent change 1981-1984		Percent change 1978-1984	
	1978	1981	1984	Population	Filings	Population	Filings	Population	Filings
Alaska:									
Superior Court	778	1,194	1,846	3%	53%	21%	55%	25%	137%
Arizona:									
Superior Court	10,390[i]	14,367[i]	15,360[i]	11%	38%[i]	9%	7%[i]	21%	48%[i]
Arkansas:									
Circuit Court	8,997[j]	14,566[j]	17,993[j]	2%	62%[j]	2%	23%[j]	5%	100%[j]
California:									
Superior Court	55,369[j]	64,993[j]	74,412[j]	6%	17%[j]	4%	14%[j]	12%	34%[j]
Colorado:									
District Court	10,604	13,868	14,783	7%	31%	7%	7%	14%	39%
District of Columbia:									
Superior Court	3,415	4,283	6,035	-6%	25%	-1%	41%	-7%	77%
Georgia:									
Superior Court	26,293	37,338	33,725	5%	42%	5%	-10%	10%	28%
Hawaii:									
Circuit Court	1,729[i]	2,291[i]	2,655[i]	6%	33%[i]	6%	16%[i]	12%	54%[i]
Idaho:									
District Court	2,845	3,302	3,649	5%	16%	4%	11%	10%	28%
Illinois:									
Circuit Court	34,260[j]	41,796[j]	46,107[j]	0%	22%[j]	0%	10%[j]	1%	35%[j]
Iowa:									
District Court	NC	8,166[j]	7,658[j]	--	--	0%	-6%[j]	--	--
Kansas:									
District Court	10,303	12,121	11,397	2%	18%	2%	-6%	5%	11%
Maine:									
Superior Court	2,790[j]	3,281[j]	3,189[j]	2%	18%[j]	2%	-3%[j]	4%	14%[j]
Minnesota:									
District Court	10,678	10,155	12,162	2%	-5%	2%	20%	4%	14%
New Hampshire:									
Superior Court	NC	3,652	3,813	--	--	4%	4%	--	--
New Jersey:									
Superior Court	24,311	29,101	37,135	1%	20%	1%	28%	2%	53%
New York:									
Supreme Court-County Court	31,506[j]	41,587[j]	49,191[j]	-1%	32%[j]	1%	18%[j]	0%	56%[j]
North Carolina:									
Superior Court	30,576	42,792	42,160	3%	40%	4%	-1%	7%	38%
North Dakota:									
District Court	916	1,233	1,284	1%	35%	4%	4%	5%	40%
Ohio:									
Court of Common Pleas	31,675	41,076	37,073	0%	30%	0%	-10%	0%	17%
Oregon:									
Circuit Court	16,097	20,198	19,913	6%	25%	1%	-1%	7%	24%
Rhode Island:									
Superior Court	2,396	4,576	4,232	0%	91%	1%	-8%	1%	77%
South Dakota:									
Circuit Court	NC	2,654	2,606	--	--	3%	-2%	--	--
Texas:									
District Court	NC	82,872	87,249	--	--	8%	5%	--	--
Virginia:									
Circuit Court	29,354	40,444	42,642	3%	38%	4%	5%	7%	45%
Washington:									
Superior Court	11,168	15,442	15,432	9%	38%	3%	0%	12%	38%
Wisconsin:									
Circuit Court	15,855[j]	14,601[j]	13,607[j]	2%	-8%[j]	1%	-7%[j]	3%	-14%[j]
Wyoming:									
District Court	1,404	1,772	1,462	14%	26%	4%	-17%	19%	4%

TABLE 36: Trend data for state courts that specifically reported triable felony case filings for 1978, 1981, and 1984. (continued)

State and court title	Filings			Percent change 1978-1981		Percent change 1981-1984		Percent change 1978-1984	
	1978	1981	1984	Population	Filings	Population	Filings	Population	Filings
Totals for 24 courts in 24 states reporting comparable data for all three years	373,809	476,361	507,444	3%	28%	3%	7%	6%	36%

Note: All of the courts listed above are general jurisdiction courts.
NC = Data are not comparable with other years.
— = Data element is not applicable.

[f] Data are incomplete:
Arizona--Some felonies are included in an unclassified category.
Hawaii--Felony figures do not include reopened prior cases included in the unclassified civil category.

[j] Explanation of data included in the category:
Arkansas--Felony figures include DWI/DUI cases.
California--Felony figures include DWI/DUI cases.
Illinois--Felony caseload data include preliminary hearings from courts "downstate."
Iowa--Felony cases include third offense DWI/DUI cases in 1981 and 1984.
Maine--Felony figures include classes A, B, and C.
New York--Felony figures include DWI/DUI cases.
Wisconsin--Felony figures include limited felony cases.

General Sportcraft Company, Ltd.
140 Woodbine Street
Bergenfield, NJ 07621
Telephone (201) 384-4242
Telex 135464
Cable Addr: Sportcraft Bergenfield

Gentlemen:

General Sportcraft Co. is a 60 year old family-owned business. Our product line includes a wide range of indoor and outdoor sport games for the home--Badminton, Croquet, Table Tennis, Tetherball, Volleyball are examples--and also some team and school sports such as Soccer, Field Hockey, Badminton and Volleyball. These products are sold to large and small retailers, chains, and to school and team dealers throughout the country, primarily under our own brandname--SPORTCRAFT. We are not manufacturers but distributors and have, incidentally, certificates of insurance and hold harmless agreements from most of our suppliers.

We are a relatively small business with approximately 100 employees. I am the second generation owner/president of Sportcraft and have operated here with a great deal of pride for close to 30 years. Our employee relations and our customer relations are very close and good. We are the recongnized leader in our little segment of the sporting goods industry, and known for the superior quality of our products.

We have been rudely awakened to the product liability crisis and now are extremely concerned with it, in fact frightened that the increasing costs of insurance and the unreasonableness of both the legal and insurance environment may result in our demise as a business.

As for the cost of insurance, here is what has happened to Sportcraft so far. When we renewed our policy on October 1, 1984 our premium for a $1 million policy with a $5 million umbrella was increased from $16,000 to $20,000.

Just six months later (mid-term) we were notified that our policy was cancelled. We were given no reason. In April 1985 we were left to flounder in the terribly unfriendly, unreceptive insurance marketplace. We had no place to go. No insurance company would take us. We were heard only by 3 of the 30 insurers we approached; they asked annual premiums as high as $650,000. Only by camping on the doorstep of the insurance company who had dropped us did I finally convince him to rescind the cancellation, with the annual premium going from $20,000 to $60,000. We had been with this carrier (one of the largest) for 4 years with a total loss experience of $71.00 (no mistake: $71.00). I never learned why our policy had been cancelled. My best guess: The insurance company determined to reduce its portfolio of liability policies. Since General Sportcraft Co. is in the sporting goods industry, they considered ours a high risk and chose our policy to cancel despite the absence of losses.

The insurance company was not prepared to renew October 1, 1985; in fact so notified us. The timeliness of Governor Thomas Kean's edict in September seemed to force insurers not to cancel nor to refuse renewal. My company was in "no-man's" land for about 60 days. By the first of this year, we had finally received verbal confirmation of an October 1, 1985 renewal at a $200,000 premium. Our premium for comparative coverage has risen from $16,000 to $200,000 within one year. The umbrella has been reduced from $5 million to $2 million. This is a tremendous hardship. We dare not "go bare" nor add this expense to the price of our products in a very competitive market. We look forward with horror to going back this summer to look for coverage for the next year.

I have limited the foregoing to some comments only on Sportcraft's insurance. Given more notice and time, I would like very much to write or address you on some of the problems we have seen and also our views regarding practices of both the insurers and the lawyers.

I cannot resist including here just one of the claims we have received. It is the most recent, though possibly not the most absurd. A claim was brought to Sportcraft on one of the products it distributes--

a wooden boomerang. A customer in a retail store had picked up this boomerang and thrown it. Apparently it performed as it should, if thrown properly. It came back and hit the clerk, a store employee. The insurance company or lawyers representing her, much to our dismay, and without any consultation with us at all, settled immediately with the store employee for $6500--not such a big amount perhaps but an absurd story in every aspect.

We are very much in need of Federal legislation and now. Tort reform is essential. Regulation of the insurance industry is essential. Limits to claims and damage awards and reduction or elimination of contingency fees are two of the major needs in my view.

Gentlemen, you are considering a very complex and a very crucial issue. Federal legislation is needed on this one. The various states with various rules and regulations cannot do the job. For us who are managing businesses throughout the country an early solution is essential. We have spawned a litigous society and created, in this area of liability, an extremely hostile environment for every business, in fact for the entire community.

Good Luck.

Respectfully,

GENERAL SPORTCRAFT CO., LTD.

KJE:BG

KENNETH J. EDELSON
President

Statement of

GARRETT KAMSTRA, VICE PRESIDENT OF FINANCE

HUTCH SPORTING GOODS, INC.

Mr. Chairman. Thank you for the opportunity to address the problem that we are facing in regard to product liability insurance.

Hutch Sporting Goods has been in business for over eighty years, from the year 1902 when founded by Mr. Stanley Hutchinson, to the present time, owned by Fuqua Industries, Inc. We manufacture and distribute a complete line of sporting goods and athletic clothing. Our work force in Cincinnati, Ohio has 130 employees, while our operations in Tennessee help create jobs for another 200 people.

Hutch has not experienced many product liability suits in its history, however in the last two years we have been named the defendant in two separate lawsuits, both of which are in excess of $1,000,000. In both instances, it appears the plaintiffs have little evidence to support their cause, however the suit continues in hopes of a major settlement.

I could give my personal opinions regarding the product liability judicial system, but I feel my personal opinions would do little good. Who is to blame for these skyrocketing costs? We could easily blame the attorneys who take these cases, the plaintiffs who have nerve to sue, the courts and juries who award unbelievable compensations, or the insurance companies themselves for putting up little or no fight at all.

The causes of premiums increasing so drastically can be related to a product that Hutch manufactures, the football helmet. Hutch has never had a lawsuit on a football helmet. However, many of our competitors have, and many have lost millions of dollars as a result.

The helmets they manufacture, as are ours, are NOCSAE, an organization begun by the manufacturers, approved. They meet industry standards and are as safe as we, at the present time, know how to manufacture them. They do not, nor are they manufactured to, protect the neck or spinal area.

Numerous awards have been given plaintiffs who have suffered neck or spinal injuries. Is the manufacturer of the helmet at fault?

There are now only four manufacturers who make football helmets and my guess is that if something regarding product liability is not changed soon, football may be a sport of the past.

We, the management at Hutch Sporting Goods, are currently involved in a leveraged buyout of Hutch from Fuqua. From a financial perspective, the deal has been agreed to, but the sale is contingent upon finding insurance at a reasonable rate. We have not been able to do this. Current quotes are at least five times the cost of our premiums paid last year. In summary, the buyout is not feasible because of one thing -- Product Liability Insurance.

Where do we go from here? We come to you and appeal to you for support. We truly hope that Washington understands the seriousness of product liability to small business. We do not want our industry to be financially hampered by this burden.

Thank you.

JAMES R. JONES
FIRST DISTRICT, OKLAHOMA
MEMBER
COMMITTEE ON WAYS
AND MEANS
CHAIRMAN
SUBCOMMITTEE ON SOCIAL SECURITY
MEMBER
SUBCOMMITTEE ON HEALTH
DEMOCRATIC STEERING
AND POLICY COMMITTEE

FEB [illegible]

Congress of the United States
House of Representatives
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February 21, 1986

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FEB 28 1986

Ways and Means
Subcommittee on Oversight

The Honorable J. J. Pickle
242 Cannon House Office Building
Washington, D.C. 20515

Dear Jake:

In the past few weeks, I have heard from a number of my constituents, particularly small businessmen, physicians and other health care professionals, about the rapidly increasing cost of liability insurance premiums.

Malpractice premiums, as you know from sitting with me on the Ways and Means Health Subcommittee, are skyrocketing, but the problem is not restricted to medicine and related fields. A number of liability insurers have cancelled policies for manufacturers and other businesses such as hazardous waste handlers, and where liability insurance is available it is almost prohibitively expensive.

Also, municipal and state governments have found it necessary to cancel certain services because liability insurance either has become prohibitively expensive or is not available.

We have heard several explanations on how this situation developed. Some blame it on the increasing size of court awards in liability cases. Others blame it on lawyers who encourage their clients to sue in any instance where damages, however minimal, befall them. Still others blame the problem on insurance companies, who for a number of years offered policies with premiums far too low to cover the cost of the policies in order to gain access to large amounts of cash, which was then put into high-yield investments.

Whatever the cause of this problem, its effects are extremely serious. A number of manufacturers have pulled their products off the market because of the number of potential lawsuits, or are considering such a move. Many companies are finding it easier to manufacture goods abroad. One manufacturer told a staff member of mine that the cost of his company's product, a lifting machine, is increased by approximately a thousand dollars because of the combination of product liability and workmen's compensation insurance.

Fear of lawsuits stifles the ingenuity and creativity of those individuals and corporations who develop new products. The added cost of insurance threatens to further erode the position of many American products in the world market.

While insurance regulation has been left, rightfully, to state governments in the past, concern over this issue is growing, and it is becoming a national problem. If nothing else, the federal government is in a position to study the problem and make recommendations to the states.

Jake, I urge you, as Chairman of the Ways and Means Subcommittee on Oversight, to conduct hearings on the issue of liability insurance. If we can at least gain a better understanding of the problem, we will be moving in the right direction.

If I can be of any help to you in this matter, please feel free to contact me. I look forward to discussing this with you further.

With best wishes,

Sincerely yours,

JAMES R. JONES
Member of Congress

JRJ/tfs

STATEMENT OF
ALLAN S. KRAFT,
VICE PRESIDENT & GENERAL MANAGER
KRAFTOURS CORPORATION; TULSA, OKLAHOMA
BEFORE THE SUB COMMITTEE ON OVERSIGHT; COMMITTEE ON WAYS & MEANS
U.S. HOUSE OF REPRESENTATIVES, WASHINGTON; D.C. 20515
THE HONORABLE J.J. PICKLE, CHAIRMAN

MARCH 10,1986

MR. CHAIRMAN, MEMBERS OF THE COMMITTEE,

I AM PLEASED TO HAVE THIS OPPORTUNITY TO PRESENT TO THIS COMMITTEE, MY VIEWS, AS WELL AS THE VIEWS OF MANY OTHER MOTOR CARRIERS OF THE SIZE OF MY FIRM IN THE BUS AND COACH INDUSTRY WITH REGARD TO LIABILITY INSURANCE AVAILABILITY AND COST. THIS IS THE SECOND TIME IN WHICH I HAVE TESTIFIED BEFORE A CONGRESSIONAL HEARING REGARDING THE ATROCITIES WHICH ARE BEING COMMITTED AGAINST SMALL BUSINESS BY THE INSURANCE COMPANIES WHO SHOULD BE WORKING TO HELP US. THE FIRST TIME WHEN I TESTIFIED, IT WAS BEFORE THE HOUSE SUBCOMMITTEE ON SURFACE TRANSPORTATION SUB COMMITTEE ON INSURANCE PROBLEMS FACING THE TRANSPORTATION INDUSTRIES, HELD ON OCTOBER 30,1985, CHAIRMAN ANDERSON, PRESIDING. BUSINESS AND TRADE PUBLICATIONS REPORT DAILY ON THE EVER EXPANDING INSURANCE CRISIS FACING MANY INDUSTRIES TODAY. LADIES AND GENTLEMEN, I AM WRITING TO YOU TODAY TO POINT OUT THE EXPERIENCES WHICH I HAVE ENCOUNTERED IN THE BUS AND COACH INDUSTRY REGARDING THIS INSURANCE CRISIS. THE INSURANCE COST FOR OUR COMPANY HAS INCREASED FOUR HUNDRED PERCENT IN ONE FISCAL YEAR! AT THE SAME TIME, THE COST PER MILE WHICH I CAN REASONABLY CHARGE MY CUSTOMER HAS NOT INCREASED AT ALL. THE QUESTION THEN BECOMES, WHY HAVE YOU NOT INCREASE YOUR RATES TO OFFSET THE INCREASE IN INSURANCE RATES? PLAINLY STATED, OUR COMPETITION IN THE MARKETPLACE IS REPRESENTED BY FEDERALLY FUNDED MASS TRANSPORTATION GRANTEES ON THE ONE HAND, AND MULTI MILLION DOLLARS CONGLOMERATES ON THE OTHER HAND. THIS COMBINATION FROM EITHER ANGLE IS VERY CAPABLE OF SELF INSURING THEIR RESPECTIVE OPERATIONS AND ALLOWING THEIR RATES TO REMAIN AT A VERY LOW LEVEL FOR THE PURPOSE OF UNFAIR COMPETITION AGAINST SMALLER, INDEPENDENTLY OPERATED FIRMS SUCH AS MINE. OUTSIDE THE POSSIBILITY FOR SELF INSURANCE WHICH IS CLEARLY OUT OF THE REACH OF SMALL COMPANIES, THERE EXISTS ONLY ONE PRIMARY INSURANCE COMPANY WHICH IS WILLING TO ACCEPT BUS AND COACH COMPANIES FOR COVERAGE, NAMELY, NATIONAL INDEMNITY. FURTHERMORE, THERE EXISTS ONLY ONE COMPANY WHICH IS WILLING TO ACCEPT BUS AND COACH COMPANIES FOR EXTENDED COVERAGE WHICH IS REQUIRED BY THE ICC. DUE TO THE FIVE MILLION DOLLAR MINIMUM REQUIREMENT ESTABLISHED IN NOVEMBER, 19,1985.

THIS MINIMUM LEVEL OF INSURANCE COVERAGE WAS INSTITUTED AT THE BEHEST OF CONGRESS IN REACTION TO INSTIGATION FOR SUCH LEGISLATION BY A VERY FEW, ENORMOUS BUS COMPANIES. WHEN THIS LEVEL OF MINIMUM INSURANCE COVERAGE WAS ADOPTED BY CONGRESS IN 1983, THE POSSIBILITY OF ACQUIRING COVERAGE AND THE COST OF SUCH COVERAGE SEEMED TO BE REASONABLY WITHIN THE REACH OF THE AVERAGE FIRM. SINCE THAT TIME, MANY INSURANCE COMPANIES HAVE GONE OUT OF BUSINESS, AND THOSE WHICH REMAIN ARE TAKING ADVANTAGE OF A DESPERATE SITUATION AND USING THE OCCASION AS A METHOD OF VASTLY INCREASING THEIR REVENUES AT THE EXPENSE OF AMERICAN BUSINESS IN GENERAL.

TODAY, WE HAVE GOOD, WELL MAINTAINED, DEPENDABLE PIECES OF EQUIPMENT FOR WHICH WE HAVE PAID MORE THAN $150,000.00 EACH IN HARD EARNED PROFIT SITTING AND RUSTING IN OUR PARKING LOT BECAUSE INSURANCE IS EITHER IMPOSSIBLE TO OBTAIN, OR FINANCIALLY OUT OF REACH. EACH OF THESE VEHICLES REPRESENTS UNEMPLOYED DRIVERS, MECHANICS, BUS WASHERS, AND OFFICE STAFF, NOT TO MENTION THE PASSENGERS WE ARE FORCED TO TURN AWAY BECAUSE IT COSTS US MORE TO RUN THE COACHES THAN WE CAN EARN IN INCOME. TO TAKE THIS ISSUE ONE STEP FARTHER, OUR INSURANCE RECORD HAS NEVER SEEN A CLAIM AGAINST OUR COMPANY IN TWENTY SIX YEARS OF OPERATION IN FORTY NINE STATES.

WE HAVE TRIED EVERY POSSIBLE WAY IN WHICH WE CAN WORK WITH THE INSURANCE COMPANIES, BUT TO NO AVAIL. WE HAVE OFFERED TO PAY THESE RATES ON A MONTHLY BASIS; WE HAVE OFFERED TO PERSONALLY ACCEPT THE FIRST TWENTY THOUSAND DOLLARS IN DEDUCTIBLE, WE HAVE OFFERED TO MAINTAIN CERTAIN VEHICLES FOR USE ONLY IN INTRA-STATE LIMITED OPERATION, ALL TO NO AVAIL. THESE COMPANIES HAVE BEEN GRANTED A MONOPOLY IN THE UNREGULATED (EITHER STATE OR FEDERAL) INSURANCE INDUSTRY, WHICH IS NOW BEING USED AS A CLUB AGAINST SMALL FIRMS SUCH AS OUR OWN. WHEN AN INSURANCE COMPANY IS KIND ENOUGH TO ACCEPT OUR BUSINESS, WITH THE NEXT BREATH, THEY ARE ASKING FOR PAYMENT IN FULL! WE HAVE EVEN BEEN THREATENED WITH TOTAL CANCELLATION IF WE QUESTION THESE POLICIES.

SOLUTIONS TO THESE PROBLEMS ARE AVAILABLE. IN THE SHORT TERM:
1. WE MUST IMMEDIATELY RETURN TO THE LEVEL OF COVERAGE WHICH WAS REQUIRED PRIOR TO NOVEMBER 19,1983. THE BUS AND COACH INDUSTRY HAS TRADITIONALLY BEEN ONE OF THE SAFEST, IF NOT THE SAFEST FORM OF TRANSPORTATION IN THE UNITED STATES AND IS THE BACKBONE OF SURFACE TRANSPORTATION ALONG WITH THE TRUCKING INDUSTRY.

2. WE MUST INCREASE SAFETY INSPECTIONS TO OFFSET THE REDUCTION IN COVERAGE. NO LEVEL OF INSURANCE COVERAGE WILL KEEP THE UNSAFE VEHICLES OFF THE HIGHWAYS. ONLY THROUGH CAREFULLY INSTITUTED ROUTINE INSPECTIONS CAN THIS BE ACCOMPLISHED.

3. WE WHOLE HEARTEDLY SUPPORT THE INITIATIVE ON THE PART OF SENATOR MITCH MCCONNELL OF KENTUCKY WHICH ATTEMPTS TO CAP PAIN AN SUFFERING AWARDS, LIMIT ATTORNEY'S FEES, AND REQUIRES PUNITIVE DAMAGES TO BE PAID TO THE COURTS, NOT TO INDIVIDUALS.

IN THE LONG TERM(ONE YEAR), THERE MUST BE POSITIVE ACTION TAKEN TO ELIMINATE THE POSSIBILITY OF THIS PROBLEM RECURRING.

1. EFFECTIVE REGULATION OF THE INSURANCE INDUSTRY FOR THE PURPOSE OF GUARANTEEING COVERAGE TO THOSE FIRMS WHICH, BY THEIR RECORD AND EFFORTS AT SAFETY DESERVE THE RIGHT TO OPERATE THEIR BUSINESSES UNENCUMBERED BY THE FETTERS OF INSURANCE PROBLEMS OF THE LIKE WE ARE SEEING HERE TODAY.

2. SIGNIFICANT STEPS MUST BE TAKEN TO ELIMINATE THE EXCESSIVE AWARDS WHICH ARE BEING GRANTED TO INDIVIDUALS IN THEIR CLAIMS.

IN CONCLUSION, I MUST SAY THAT WE AMERICANS HAVE CONFIDENCE THAT, GIVEN TIME, WE CAN SOLVE ANY PROBLEM AND WEATHER ANY STORM. UNFORTUNATELY, IT OFTEN TAKES A CRISIS TO MAKE US ACT. I STRONGLY BELIEVE THAT CONGRESS WILL SEE THE IMPOSSIBILITY OF THE SITUATION WITHOUT ITS INTERVENTION AND WILL ASSIST ALL SMALL BUSINESS IN THE PROBLEMS WHICH WE HAVE FACED OVER THIS DEBACLE OF INSURANCE. WE MUST SAY THAT WE ARE INDEBTED TO OUR REPRESENTATIVE, JAMES R. JONES TO ALERTED US TO THE EXISTENCE OF THESE HEARINGS AND ASSISTED OUR PRESENTATION OF THIS WRITTEN TESTIMONY.

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Ways and Means
Subcommittee on Oversight

March 27, 1986

The Honorable J. J. Pickle
Chairman of the Subcommittee
on Oversight
The United States House of
Representatives
Washington, D.C. 20515

Dear Congressman Pickle:

In reference to your subcommittee's inquiry into the unavailability of liability insurance, I would like to suggest some areas where the federal government can play a role and which will not require an upheaval of the present regulatory patterns that exist in our respective states.

I am former the New York State Superintendent of Insurance having served in that capacity from 1978 through 1983 and prior thereto I was a New York State Senator for six terms where I served on the Insurance Committee. I am presently an attorney specializing in regulatory practice.

I would like to suggest an area where federal posture and legislation may be valuable. The industry will agree that part of the lack of capacity was caused by a series of insolvencies of major carriers and will be further affected by other insurers' insolvencies.

The present state insolvency laws have no solution as the federal bankruptcy laws have to rehabilitate and reduce the cost of the insolvency. On the contrary, each state becomes its own fiefdom with a escalation of legal fees, accountants, and duplication of effort.

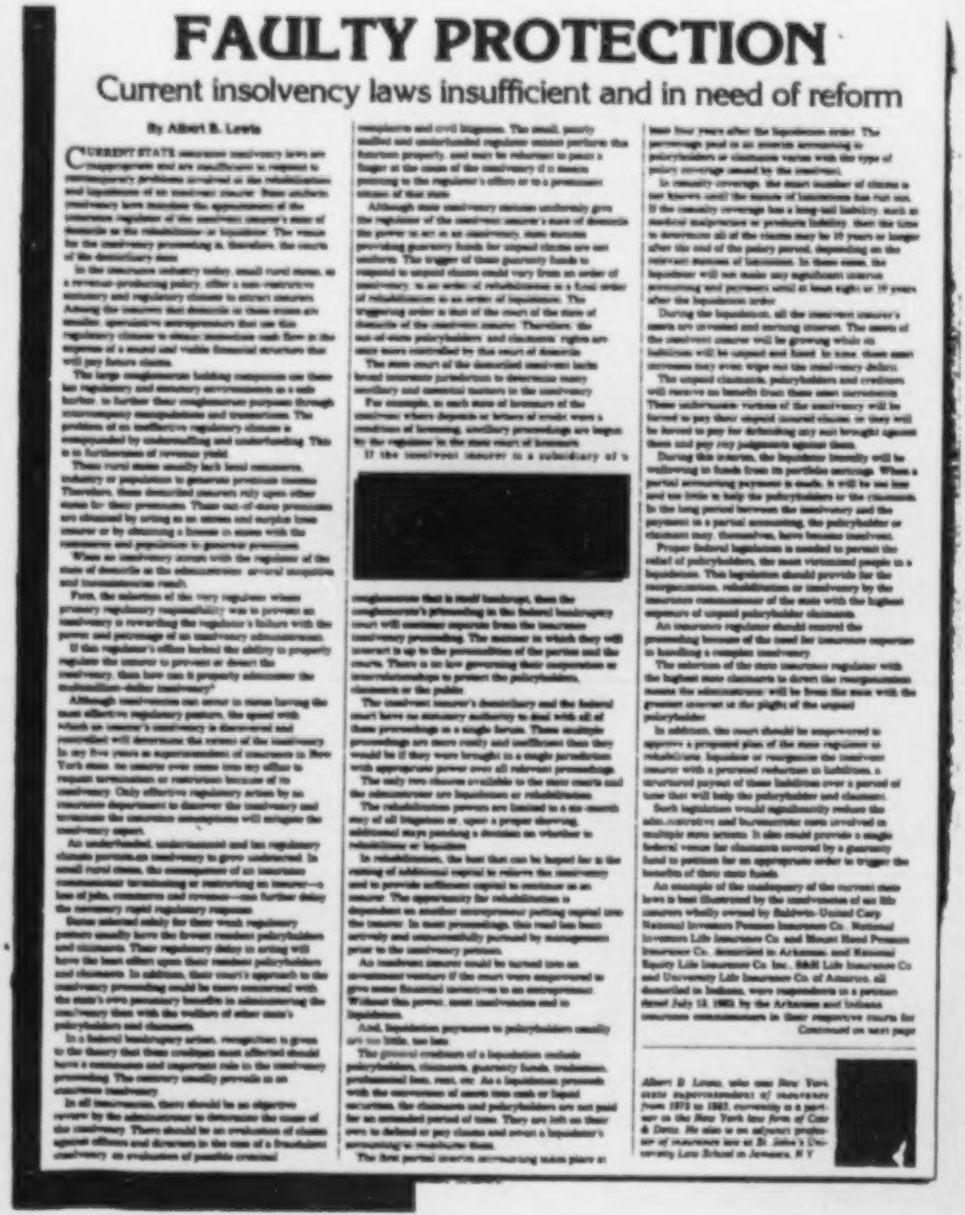
I am enclosing herewith an article which will be self-explanatory in approaching some of the problems that presently exist. The federal government could legislate an approach that will unify all litigation into one single federal jurisdiction, set up authority to attempt to compromise and adjust lost reserves against insurers to permit rehabilitation. If you consider the fact that in an insurance insolvency most carriers are left with substantial assets which are, of course, overwhelmed by future lost payments. This situation lends itself to a rehabilitation approach and yet it is impossible under state law to obtain any sort of compromise or adjustment since each state operates independently and in its own self-interest.

I do not in any way support federal regulation or federal legislative intrusion in the operation of insurance companies. However, after they become insolvent, I believe there should be a federal judicial forum with a state regulator as receiver who has the expertise and has the largest group of claimants.

I would be pleased to work with you in this matter.

Very truly yours,

Albert B. Lewis



FAULTY PROTECTION

Current insolvency laws insufficient and in need of reform

By Albert B. Lewis

Continued on next page

State insolvency laws are in need of reform

Continued from previous page

an order of rehabilitation of their domiciled insurers.

The total policyholder liability for the companies was more than $4.83 billion, representing mostly single-premium deferred annuities. The Arkansas and Indiana insurance departments are among the smaller state insurance departments in terms of staff and funding. The six companies were the largest in the country writing single-premium deferred annuities.

They all were involved in intercompany financial transactions that they called reinsurance and retrocessions, but there was no real risk transfer out of these commonly owned companies. These fund transfers were to respond to management's plans for tax avoidance and to fund their parent conglomerate's acquisitions.

The transfers eventually resulted in some $900 million investment in Baldwin-United subsidiaries for these six insurers' portfolios.

In the transfer, the funds were moved between the Arkansas and Indiana insurers. In the rehabilitation proceeding, the two states decided to handle the six companies' rehabilitation as a single pool and not untangle each of the intercompany transactions. This decision was based on the rehabilitators' belief that if these transactions were unraveled, it would be inequitable and disadvantageous to some of the policyholders and it also would result in complex and uncertain counterproductive litigation between the rehabilitators.

Neither rehabilitator nor state court considered the cost and saving or the productivity of having one rehabilitator instead of two, and thereby avoiding duplication of work. In the interest of maintaining each state's right to the patronage and power of this large, multibillion-dollar proceeding, the policyholders' and claimants' rights were subordinated.

Both states' proposals of rehabilitation were opposed by several parties recommending modification; however, the courts of both issued identical orders approving the rehabilitation plan.

While these rehabilitation plans were approved, a rash of lawsuits arising out of these insolvencies were instituted. A federal bankruptcy action was instituted against the Baldwin-United parent. Class actions were instituted in the federal courts against brokers and agents who marketed the policies.

In the class action, six state guaranty associations intervened to oppose a proposed settlement by the stockbrokers-agents. These associations intervened almost 18 months after the suit was begun, alleging that the settlements were insufficient and that these state guaranty associations could be liable for any losses suffered by their residents.

In 12 states where the Baldwin-United life insurers were licensed, ancillary actions were commenced by these state regulators to take possession of any deposits and letters of credit held in these states.

Arkansas and Indiana policyholders of these companies are the fewest in number and the smallest in dollars of liability. The rehabilitation orders of Arkansas and Indiana were interlocutory orders and not the final orders of rehabilitation that would have triggered many of the states' guaranty associations to pay policyholder claims. Because the orders were interlocutory and not final, the rights of those out-of-state policyholders to be repaid their losses by their state guaranty funds were held in limbo.

Ninety-five percent or more of the $4.83 billion in policyholder liability represented single-premium deferred annuity policies, and many of these policyholders were retired or elderly people, to whom these policies represented their life savings. The anxieties of these policyholders could have been removed by payments from their state guaranty funds.

In the Baldwin-United bankruptcy proceeding, the Internal Revenue Service has indicated a joint and several liability of Baldwin-United and its subsidiaries of some $460 million. In addition, it is alleged that the intercompany transactions by the six life insurers may have increased the tax liability of some of the companies by disqualifying them as life insurers.

The rehabilitation called for in the Indiana and Arkansas orders was not really a rehabilitation, but was in reality a liquidation that delayed for a period of 3½ years the payment or redemption of the single-premium deferred annuities. The restriction of policyholders' ability to redeem their policies for 3½ years gave the regulators the opportunity to accumulate the interest earned over 3½ years and to use it to offset the deficits.

The problems raised by state insolvency laws in this matter include the costly duplication of rehabilitations in two states, the multiple actions pending in other states' courts concerning the insolvent companies and the failure of the Arkansas and Indiana courts to issue a final order of rehabilitation so that policyholders of other states with guaranty funds could be recompensed.

In addition, the bankruptcy reorganization plans being considered for the parent conglomerate are not involved in the dual state administration of the six insurers. The class-action suits in the federal court numbered 300 or more, which were consolidated under the multiple litigation rules of the federal court into a single proceeding.

If, as has been alleged in class actions against the brokerage firms that sold the single-premium deferred annuities, the annuities are security transactions subject to Securities and Exchange Commission rules and law and are not life insurance policies in that they lack a mortality contingency, then their insolvency may be subject only to federal bankruptcy jurisdiction.

If these companies were subject to the federal bankruptcy laws, then there would be no duplication of rehabilitations and no need for ancillary proceedings. The reorganization of these companies would all be within a single court jurisdiction, and the creditors' committee would be made up of a class of creditor policyholders represented by a claimant from a state with significant liability exposure.

[redacted]

The federal court would have no problem triggering the guaranty funds by a final order of rehabilitation or by calling the procedure what it is—a liquidation, delayed by 3½ years. The result would be a less costly administration and a higher yield to the policyholder.

The case of the Ambassador Insurance Co. of Vermont further highlights the inadequacy of state insolvency laws.

Ambassador is domiciled in Vermont and wrote insurance in 49 states and the District of Columbia. The claims of Vermont policyholders represent less than 1% of the loss reserves. The Vermont Insurance Department also is among the smaller insurance regulatory offices.

The Vermont Insurance Department did not act to assume control of the company and obtain an order of liquidation until the insolvency reached more than $313.5 million. In some states, guaranty funds will be responsible for the claims. In most, however, the claimants and policyholders are left without coverage.

The Vermont court, after a contested action by Ambassador's management, has ordered the company's liquidation. Some of Ambassador's malpractice insurance policyholders are non-profit hospitals. This insurance covers long-tail liabilities and has large incurred-but-not-reported claims.

The liquidation, therefore, will be prolonged and should extend until the statute of limitations on medical malpractice has been exhausted on claims incurred during the policy period. In New York, for example, the statute of limitations could be as long as 26 years for claims occurring before July 1, 1975, and 10 years on a claim occurring after July 1, 1975. The liquidation will not provide any immediate funds to the insured to settle or pay claims until many of the suits have been concluded.

The liquidation is irrelevant to the immediate problem of the claimants and the policyholders. The non-profit hospitals that purchased Ambassador malpractice insurance may be forced into bankruptcy themselves, triggering insolvency clauses in leases, mortgages and other contracts. This approach will have a catastrophic effect on the delivery of health care in the areas around these hospitals.

In the Ambassador proceeding, an offer was made to avoid the liquidation by purchasing a single-premium deferred annuity with the liquid assets of the insolvent insurer.

The offer would use $85.8 million of the company to obtain an insurers' agreement to pay $100 million over 11 years for payment of claims and creditors. If this had been accepted by the Vermont commissioner, the proposed offer would have been to give the company a positive net worth in 11 years.

The payments of the $100 million were not pledged to coincide with claim maturity but were structured to permit the obligor to use the interest income from the $85.8 million and thereby increase the funds available for claims.

The proposal was rejected by the commissioner on the grounds that only a full loss-portfolio transfer, in which there would be an unequivocal assumption to pay all claims when due, would satisfy statutory solvency.

In short, the commissioner's prerogatives were limited to a situation of all or nothing at all. The commissioner found other objections to the proposal, one of which was that it provided excess profit to the insurer and the brokers who formulated the proposal.

The commissioner indicated that he could purchase a single-premium deferred annuity at lower cost and higher yield, and that he may in fact purchase one in his efforts to preserve the Ambassador estate during liquidation.

This action by the commissioner to save the estate unnecessary cost or commission is laudatory, but it will not help the policyholders facing liquidation, judgments and claims.

If the court had the power to order a structured payment program and/or a partial reduction of claims, then the assets of the insolvent insurer could be used in an immediate program to help claimants and policyholders.

In the Ambassador case, while the Vermont commissioner is concerned about protecting the estate from depletion by rejecting this plan, he has incurred some $11.436 million in expenses between Nov. 10, 1983 and Oct. 31, 1984, of which more than $2.34 million represents rehabilitation expenses. The Vermont commissioner used a law firm in Ohio, which cost $732,879, a law firm in Washington, which cost $170,110, and a consulting firm in New York, which cost $496,072.

Other states in which Ambassador was licensed have begun proceedings to assume control of Ambassador deposits and letters of credit. In a bankruptcy proceeding, these additional actions could be consolidated in the single court, and the court could approve a proposal to reduce the claims and vendor obligation by a specific percent and/or a graduated payout of claims over time. There could be a reserve for IBNR claims, to be held until the claims are better defined. Claims pending or involved in litigation could be subject to arbitration proceedings.

The policyholders and claimants could be protected from the specter of insolvency by a prescribed and scheduled flow of funds from the assets and their earnings. Policyholders and claimants would be able to negotiate settlements around these payments. Guaranty funds also would benefit by these partial payouts and, since guaranty fund payments ultimately are paid by the insurance buyer, the consumer also would benefit.

This type of new alternative to the policyholders and claimants of an insolvent insurer is far more responsive than a partial payout seven years in the future. Industry would be relieved of funding a guaranty association and/or the administrative cost of liquidation would be controlled by the single federal court.

Only the lawyers and accountants would be adversely affected.

Model Statutes Causing Problems In Insolvencies of Insurers

By Albert B. Lewis

The National Association of Insurance Commissioners adopted a model act in 1969 providing for a post-insolvency assessment insurance guaranty fund. Every state except New York has adopted a form that is similar to the model act. These state statutes are presently causing chaos in the aftermath of the Ideal Mutual Insurance Company insolvency and liquidation. The chaos will cause lawyers to become richer, insureds to become poorer, and extended litigation between states and claimants. Federal legislators are sure to respond in an attempt to solve the problem or inadvertently contribute to it.

Problems with Statutes

The difficulties with the so-called model statutes is that although many are similar, too many are materially different. Some states provide a $50,000 maximum per claim coverage, some up to $1 million. Some states prohibit claimants with certain maximum net worth from being eligible for any fund coverage. Some other states exclude products liability and limit claims to economic loss only. In addition to differences in the amount of the guaranteed claim, are the broad definitions of a covered claim in these laws which raise multi-state conflicts of law questions as to coverage. These questions will cause serious delays and litigation to determine state guaranty fund coverage.

Albert B. Lewis, a partner in the firm of Cole & Dietz in Manhattan, is a former New York State Superintendent of Insurance.

New York State has its own definition of a covered claim: It is "a claim based upon a policy insuring property or risks located or resident in this state" (7602 and 7603 N.Y. Insurance Law). The Model Act's definition of a covered claim is one where the claimant or the insured is a resident of the state at the time of the insured event or the property from which the claim arises is permanently located in the state. Either definition leaves more questions than answers.

In first-party property coverage, the Model Act or the New York Act pose no conflict since location of the risk or property from which the claim arises is readily ascertainable. Under the Model Act, third-party casualty coverage where the claimant and the policyholders have different state residences, then two state guaranty funds could be covering the claim. If, in addition, the property that caused the loss is in another state, then still another guaranty fund could be liable. If the property is in New York, then New York State's guaranty fund statute could provide coverage. In a large casualty loss claim involving several state guaranty funds with different limits, the insured is materially interested in having maximum coverage by having the state guaranty fund with the maximum per claim fund respond.

Products Liability Coverage

Products liability coverage may contain more multi-state contacts. The location of a products liability risk could be the state where a product is sold, leased, used, ingested, repaired, assembled or manufactured. The question of which state guaranty fund will pay a multi-state claim against an insolvent insurer's policy is a problem that is facing all of the Ideal Mutual Insurance Company and Union Indemnity casualty policyholders.

Ideal Liquidated

Ideal, a New York domiciled insurer, was declared insolvent and an order of liquidation was granted by the New York Supreme Court on Feb. 7, 1985. Ideal was licensed in the fifty states and wrote a large amount of liability coverage, including products liability, across the United States.

On Feb. 19, 1985, notices were placed in the *Journal of Commerce* and were mailed to all Ideal policyholders and claimants stating the term of the order of liquidation. The notice contained the following statement:

"All persons and policyholders against whom actions are now pending who do not come within the provisions of Section 7601, 7603 and 7604 of the New York Insurance Law concerning which the Company (Ideal) may be liable on its policies or contracts and which have been defended up to date of the order of liquidation by an attorney ... retained by the Company are advised that the ... retention of said attorney has been terminated by the entry of the order of liquidation. EACH SUCH PERSON IS THEREFORE ADVISED TO CONTACT THE INSURANCE DEPARTMENT, GUARANTY FUND OR ASSOCIATION IN YOUR STATE."

In another part of the notice, claimants were advised to file a proof of claim before Feb. 7, 1986, whether or not a claim has been filed against them.

Union Indemnity's Insolvency

Union Indemnity Insurance Company was found to be insolvent by the New York Supreme Court on July 16, 1985, pursuant to a petition of the New York Insurance Superintendent alleging a $125 million insolvency. A similar notice for Union Indemnity's policy holders was published on Aug. 16, 1985, setting July 17, 1986, as the date on or before which a proof of claim must be filed.

Thus, the policyholder is left in a quandary to first determine if the claims that are known to him are covered by §§ 7601, 7603 and 7604 of the New York Insurance Law. The difficulty of determining just what is meant by the New York statute concerning risks located or resident in the state is enough to challenge courts and lawyers, let alone policyholders. The direction "to contact the Insurance Department, Guaranty Fund or Association in your state" creates the second problem to define which state is "your state" when an insured has multi-state offices or operations.

NEW YORK LAW JOURNAL—Thursday, August 22, 1985

If, in fact, some understanding of the applicability of these statutes can be determined as to reported claims, where does the policyholder file a proof of claim, as to the incurred but not reported claims (IBNR)? How can the policyholder determine the applicability or non-applicability of §§ 7601, 7603 and 7604 on IBNR or on an unreported claim?

As the notice of the liquidator states, if New York State's statutes do not apply, then the insureds should contact some other guaranty funds. Which one may become critical to the insured's ability to obtain coverage for the claim? An insured who is in a state that limits the payment to $50,000 per claim and is a defendant in a suit that exposes it to a claim well over $50,000 is left personally exposed for the difference. An insured with a net worth that prohibits him from being covered by a state's guaranty fund is even more exposed. The unequal provisions in the states' statutes will give rise to insureds seeking a state guaranty fund that will maximize their coverage. The insured in a state with low claim coverage will attempt to find coverage in the state where the plaintiff is a resident if that state has a greater coverage. Insureds will be filing proofs of claim with selected state guaranty funds and these funds may reject these claims on statutory grounds. The litigation that will ensue will be prolonged, extensive and multi-state.

Guide for States

Some litigation involving prior insolvencies has already occurred and may be used as a guide to other states. The New Jersey Property Liability Association refused coverage on a first-party claim arising out of a policy that covered a steel dredging barge. The claim was for damage to the barge occurring in the Atlantic Ocean off Long Island. The Association claimed that the barge was not in New Jersey and therefore, did not qualify as property permanently located in New Jersey. The plaintiff, a corporation domiciled in Delaware, claimed coverage as an insured resident of the state. The New Jersey Superior Court found coverage based upon the insured being a resident of New Jersey. The plaintiff corporation's domicile in Delaware was discounted by the court as not being synonymous with residency. It held that irrespective of a corporation's domicile, its residence was determined by its being licensed by New Jersey to transact business and its operation of its principal place of business in New Jersey. These facts were sufficient for the court to find coverage under the New Jersey statute which uses the model law definition. *Eastern Seaboard Pile Driving Corporation v. New Jersey Property Liability Insurance Guaranty Association* (175 N.J. Super 588, 1980).

In the Eastern Seaboard Pile Driving Corporation case the New Jersey Superior Court differentiated their decision from a previous decision in *State v. Garford Trucking Inc.* (4 N.J. 346, 1950) and *Red Star Express Lines v. DeStefano* (104 N.J. Super 102 (App. Div. 1968)). Both of these cases involved motor vehicles.

In *Garford*, a New Jersey corporation was charged with operating an unregistered motor vehicle in New Jersey in violation of the New Jersey Motor Vehicle Laws. The defendant claimed it was exempt from registration in that it was licensed to do business in several states, operated his The court held that the corporation could not become a non-resident of New Jersey, its domiciled state. It could not shed its residence "which is inseparable from domicile" (4 NJ 351).

The court, in *Eastern Seaboard Pile Driving*, found this language did not suggest that a corporation may not become a resident of a jurisdiction in addition to that of its origin and it quoted the *Garford* decision, "Unlike a natural person, a corporate entity cannot change its domicile at will although it may have a residence elsewhere for the transaction of its business ... Ordinarily, domicile includes residence but one may have several residences or places of business ... a domestic corporation whose domicile and residence in this state are inseparable incidents of the charter which gives it being, does not become a 'nonresident' by transacting business in another sovereignty, even though it may also have a residence there for certain purposes" (6 NJ 352-353).

The court in *Garford* cited *In re Roche* 16 N.J. 579 1954, that although a domestic corporation does not become a nonresident of its domiciliary by transacting business in another sovereignty,"it may have a residence there for the purposes ordained by the foreign jurisdiction" (16 NJ 588).

Red Star Express Case

In *Red Star Express*, plaintiff was a domiciled New York corporation, transacting business in New Jersey. It sought payment for damage to its truck occurring in New Jersey. The plaintiff alleged it was a resident of New Jersey and eligible under the New Jersey Guaranty Fund definition of claim coverage. The court held that the truck was registered in New York and therefore not the subject of contribution to the fund from which payment was to be made and that, therefore, it was the legislative intent that payment would be made only to those who in some way had contributed to the fund. In addition, the court stated that Red Star's registering the truck in New York was further evidence that it did not consider itself a resident of New Jersey. The New Jersey statute required "every resident of this state" (N.J. §A-39:34) to register their vehicles in New Jersey.

Delaware, a state with many domiciliary insureds, evidently amended its model statute by adding the following: "For purposes of determining residence under this section, if the insured is a corporation which transacts business outside of the state of incorporation, recovery shall be sought in that jurisdiction where a principal place of business most closely related to the claim is located." (Delaware Code Ann Tit 18 Sec 4212(c) Supp 1982).

These New Jersey decisions may leave more unanswered questions for Ideal insureds than they answered. They establish residency as existing in the state of domicile and establishes additional residency in other states based upon several factors, licensing to do business in a state, the establishment of an executive office or principal place of business in a state. These factors create more state contacts and more confusion for the Ideal casualty policyholders of insolvent insureds.

Added Difficulties

If the difficulties inherent in the various laws ae not enough, the State of Texas has set a cut-off date for Ideal policyholders' claims to be filed as Jan. 16, 1986, and Nebraska as Sept. 13, 1985. These different dates add further confusion to the Ideal insureds who have been advised of a cut-off date of Feb. 7, 1986 by the New York Insurance Superintendent.

To protect the right to claims against a guaranty fund, it may be necessary for Ideal and Union Indemnity policyholders to file their proof of claim with the state of residency of a known claimant where that state has a higher claim limitation than that of the insured's state of residency and, wherever it is possible, for the insured to establish a residence in a state with a higher claim coverage to file with that state. As to IBNR claimants, the proof of claim should be filed in every state where the claim limitations are higher than the state of residency of the insured.

The Ideal and Indemnity problem highlights a basic inequity in the guaranty legislation of the states. Insureds paying the same premium to the same regulated carrier will be left with unequal guaranty fund coverage. Some insured residents of New York State may be without coverage if the definition of "risk resident" in New York State fails to cover them for a product manufactured in a sister state or imported into the U.S. state without being stored or sited in New York State. It also may be unequitable to the New York insurance consumers who have contributed to the New York pre-insolvency fund to have a nonresident claimant or insured receive payment out of the fund solely because the product was built, manufactured or sited in New York State.

This present inequity in the uniform guaranty legislation may cause the Federal Government to pre-empt the state jurisdiction.

William S. James
Treasurer

Edwin J. Semans
Chief Deputy Treasurer

State Treasurer's Office
P. O. Box 666
Annapolis, Maryland 21404

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Ways and Means
Subcommittee on Oversight

March 26, 1986

The Honorable J. J. Pickle
Chairman
House Ways and Means Oversight
Subcommittee
House of Representatives
Washington, D. C. 20515

Dear Chairman Pickle:

I read with interest the article in The Daily Record and noted that you seemed to be surprised by Griffin Bell's suggestion. I am enclosing a legislative proposal now pending in the General Assembly of Maryland, which carefully drafts a conservative proposal following Mr. Bell's suggestion. My daughter, Mary-Dulany James, has made a careful study of punitive damages, and if you are interested, I can send you a lengthy thesis on the subject.

With kindest regards, I am

Sincerely yours,

WILLIAM S. JAMES, TREASURER

WSJ:mm
Enclosures

THE DAILY RECORD Tuesday, March 25, 1986

Punitive damages should go to government Bell urges

By Karen W. Arms
United Press International

WASHINGTON — Former U.S. Attorney General Griffin Bell, testifying Monday in Congress on the soaring costs of liability insurance, dropped what one member called a "bombshell" by proposing the government get a share of awards to victims.

Bell said there should be a cap on punitive damages — those exceeding what an injured party might be awarded for costs and for "pain and suffering."

"I would also provide that punitive damages be paid, since they amount to fines, to the state or federal government, as the case may be," he said.

Bell said he does not favor limits on other damages. "I do not believe that I would put a cap on damages for pain and suffering," he said at continuing hearings on liability insurance before the House Ways and Means oversight subcommittee.

Bell's proposal apparently caught Chairman J.J. Pickle, D-Texas, by surprise.

"I haven't heard that recommendation before," the Texas Democrat said. "It's kind of like a bombshell."

Bell, now a member of an Atlanta law firm, said punitive damages are "like a fine" and intended to punish wrongdoers.

"It would be fair to give to all of the people by putting it in the state treasury," he told Pickle.

Bell, the first witness at the third day of hearings on the issue, backed proposals for bringing liability cases under the jurisdiction of federal courts rather than under widely differing and even conflicting state laws.

Mayor Frank Cooksey of Austin, Texas, said his city and others have had trouble getting liability insurance to cover "catastrophic" losses. Austin, he said, is now dependent on "complete self-insurance."

Spokesmen for small businesses also reported similar problems in getting liability coverage and said many could be forced out of business.

John Parish, the president of a Tennessee baseball equipment manufacturer, said in testimony for the Sporting Goods Manufacturers Association that the situation had become a nightmare for his industry.

The insurance problem, he said, "may result in the demise of the sporting goods industry."

Similar complaints came from spokesmen for bus and truck operators.

GRIFFIN BELL

Since punitive damages amount to fines, they should be paid to the government.

SENATE OF MARYLAND

6lr3240 No. 854 D2

By: Senator Lapides (By Request)
Introduced and read first time: February 10, 1986
Assigned to: Judicial Proceedings

A BILL ENTITLED

AN ACT concerning

Civil Actions - Punitive Damages

FOR the purpose of requiring a party seeking punitive damages in a civil action to prove all elements of the punitive damages claim by clear and convincing evidence; authorizing a court to calculate the amount of punitive damages; requiring punitive damage awards to be paid to the General Fund of the State, with certain exceptions; requiring a court to consider certain factors in calculating the punitive damage award; permitting punitive damages to be awarded in tort actions arising from a contract under certain circumstances; authorizing a court to award reasonable attorney's fees out of the punitive damage award to be paid to the General Fund; providing for the applicability of the Act; repealing all inconsistent laws; and generally relating to punitive damages.

BY adding to

Article - Courts and Judicial Proceedings
Section 11-2A-01 through 11-2A-07, inclusive to be under the new subtitle "Subtitle 2A. Punitive Damages"
Annotated Code of Maryland
(1984 Replacement Volume and 1985 Supplement)

Preamble

WHEREAS, There is a national trend toward expanding the application of punitive damages beyond the traditional malicious tort framework to include cases such as bad faith breach of contract claims, fraudulent violations of State securities law, and product liability actions; and

WHEREAS, There has been a startling increase in the number of cases in which punitive damages have been recovered and in the amount of these awards; and

---

EXPLANATION: CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.
[Brackets] indicate matter deleted from existing law.

WHEREAS, The increase in both the frequency and size of punitive damages awards has the potential for severe widespread economic consequences; and

WHEREAS, The potential for recovering excessive punitive damages promotes frivolous lawsuits and ill-premised settlements; and

WHEREAS, Punitive damages are a financial gain and an unwarranted windfall to those plaintiffs, who have already regained all their losses, both tangible and intangible through the expanded concept of compensatory damages; and

WHEREAS, Punitive damages are assessed for reasons of public policy and in the interest of society, not as a reward to the plaintiff, but as a punishment to the defendant and as a deterrent to the defendant and others; and

WHEREAS, The common law of Maryland provides no guidelines for assessing an appropriate amount of punitive damages, juries are inexperienced and ill-equipped to mete out punishment that will be in the best interest of society, and judges have expertise in the delicate issues of economics and social policy and have experience in imposing punishments on defendants; and

WHEREAS, The imposition of punitive damages in civil cases is closely akin to the imposition of monetary sanctions in criminal cases, but the doctrine of punitive damages does not provide the defendant with the procedural safeguards affording in criminal proceedings; and

WHEREAS, The rule which prohibits the recovery of punitive damages in cases where the tort arises out of a contract unless there is a showing of actual malice permits otherwise reprehensible conduct to go unpunished; and

WHEREAS, To control the award of punitive damages there is a need for legislative intervention to correct the deficiencies of the common law of Maryland; now, therefore,

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article - Courts and Judicial Proceedings

SUBTITLE 2A. PUNITIVE DAMAGES

11-2A-01.

THE PURPOSE OF THIS SUBTITLE IS:

(1) TO ESTABLISH PROCEDURES FOR AWARDING AND ALLOCATING PUNITIVE DAMAGES TO INSURE THE EQUITABLE AND JUST METING OUT OF PUNISHMENT IN CIVIL CASES;

(2) TO REQUIRE THAT ALL ELEMENTS OF A CAUSE OF ACTION FOR PUNITIVE DAMAGES BE PROVEN BY CLEAR AND CONVINCING EVIDENCE;

(3) TO AUTHORIZE THE COURT TO DETERMINE THE AMOUNT OF PUNITIVE DAMAGES;

(4) TO DIRECT ANY PUNITIVE DAMAGES PERMITTED AND RECOVERED TO BE PAID TO THE GENERAL FUND OF THE STATE;

(5) TO PERMIT THE COURT, IN CERTAIN LIMITED CIRCUMSTANCES, TO APPORTION THE AWARD OF PUNITIVE DAMAGES BETWEEN THE PLAINTIFF AND THE GENERAL FUND OF THE STATE;

(6) TO PROVIDE GUIDELINES FOR DETERMINING WHAT CONSTITUTES AN APPROPRIATE AWARD OF PUNITIVE DAMAGES; AND

(7) TO PERMIT THE RECOVERY OF PUNITIVE DAMAGES IN CASES WHERE A TORT ARISES OUT OF A CONTRACT BY A SHOWING OF EITHER ACTUAL OR IMPLIED MALICE.

11-2A-02.

IN ALL CIVIL CASES IN WHICH PUNITIVE DAMAGES ARE SOUGHT, ALL ELEMENTS OF A CLAIM FOR PUNITIVE DAMAGES SHALL BE ESTABLISHED AND PROVEN BY CLEAR AND CONVINCING EVIDENCE.

11-2A-03.

IN ALL CIVIL CASES IN WHICH PUNITIVE DAMAGES ARE SOUGHT:

(1) THE TRIER OF FACT SHALL DETERMINE THE LIABILITY OF THE DEFENDANT FOR COMPENSATORY AND PUNITIVE DAMAGES, AND SHALL AWARD COMPENSATORY DAMAGES; AND

(2) THE COURT SHALL CALCULATE THE AMOUNT OF APPROPRIATE PUNITIVE DAMAGES.

11-2A-04.

(A) EXCEPT AS PROVIDED IN SUBSECTION (B) OF THIS SECTION, IN ALL CIVIL CASES IN WHICH AN AWARD OF PUNITIVE DAMAGES HAS BEEN AWARDED, THE DAMAGES SHALL BE PAID TO THE GENERAL FUND OF THE STATE.

(B) IN CASES IN WHICH THE AWARD OF COMPENSATORY DAMAGES FAILS TO ADEQUATELY COMPENSATE THE PLAINTIFF, OR THE AWARD OF COMPENSATORY DAMAGES FAILS TO ADEQUATELY RECOGNIZE A PUBLIC SERVICE RENDERED BY THE PLAINTIFF IN PROSECUTING THE CASE, THE COURT MAY APPORTION THE AWARD OF PUNITIVE DAMAGES BETWEEN THE PLAINTIFF AND THE GENERAL FUND OF THE STATE.

11-2A-05.

THE COURT SHALL CONSIDER THE FOLLOWING FACTORS IN AWARDING PUNITIVE DAMAGES:

(1) THE FINANCIAL STATUS OF THE DEFENDANT;

(2) THE COMPLEXITY AND DURATION OF THE TRIAL;

(3) THE AMOUNT OF COMPENSATORY DAMAGES AWARDED;

(4) ALL PRIOR CRIMINAL AND CIVIL PENALTIES, INCLUDING PRIOR PUNITIVE DAMAGE AWARDS, IMPOSED ON THE DEFENDANT FOR THE CONDUCT AT ISSUE;

(5) PUBLIC POLICY;

(6) THE ECONOMIC REPERCUSSION OF THE AWARD; AND

(7) THE DETERRENT EFFECT OF THE AWARD ON THE DEFENDANT AND ON SIMILARILY SITUATED PERSONS GENERALLY.

11-2A-06.

AN AWARD OF PUNITIVE DAMAGES IS PERMITTED AS PROVIDED IN THIS SUBTITLE IN CASES IF EITHER ACTUAL OR IMPLIED MALICE IS PROVED, WHERE A TORT ARISES OUT OF A CONTRACT.

11-2A-07.

THE COURT MAY AWARD REASONABLE ATTORNEY'S FEES FROM THAT PORTION OF THE PUNITIVE DAMAGE AWARD ALLOCATED TO THE GENERAL FUND OF THE STATE.

SECTION 2. AND BE IT FURTHER ENACTED, That the provisions of this Act may not be construed to apply to a civil action filed before July 1, 1986.

SECTION 3. AND BE IT FURTHER ENACTED, That all laws or parts of laws, public general or public local, inconsistent with this Act, are repealed to the extent of the inconsistency.

SECTION 4. AND BE IT FURTHER ENACTED, That if any provision of this Act or the application thereof to any person or circumstance is held invalid for any reason, the invalidity shall not affect the other provisions or any other application of this Act which can be given effect without the invalid provisions or application, and to this end all the provisions of this Act are declared to be severable.

SECTION 5. AND BE IT FURTHER ENACTED, That this Act shall take effect July 1, 1986.

Thomas E. McNamara, M.D., S.C.
AMERICAN BOARD OF FAMILY PRACTICE
1325 SO ARLINGTON HEIGHTS ROAD
ELK GROVE VILLAGE IL 60007

TELEPHONE 439-7284

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MAR 26 1986
Ways and Means
Subcommittee on Oversight

March 19, 1986

Representative J.J. Pickle
Chairman of House Ways and Means Oversight Subcommittee
1105 Longworth
House Office Building
Washington, DC 20515

Attn: Beth Kuntz

Dear Representative Pickle:

If a physician saves the life of a patient, he or she is certainly not entitled to one-third of the patient's lifetime earnings in compensation for this. How then can a lawyer demand a similar sum in the case of a wrongful death?

I urge your committee to recommend widespread limitations on attorney fees.

Please add this letter to the hearing record and give carbon copies to the committee members.

Sincerely yours,

Thomas E. McNamara, M.D.

TEM/lm

6600 Artesia Boulevard
Buena Park, Calif. 90620
(714) 670-9400
Telex: 910-583-1426

March 24, 1986

The Honorable
J. J. Pickle
Chairman, Subcommittee on Oversight
House Ways and Means Committee
Washington, D.C. 20515

Merchants
Corporation
of America

Re: Hearings on the Cost and Availability of Liability Insurance

Dear Congressman Pickle:

Merchants Corporation has been in business since 1977. From a modest beginning with four employees, it has grown to where it currently employs approximately 55 persons in its Los Angeles facility and 15 persons in the New York/New Jersey area. Annual sales volume is approaching $50 million.

Merchants has three product divisions. The two primary divisions, Aprica baby products and MCA Sports exercise equipment, have a tradition of innovation, quality, and value. They hold leadership positions in their market segments. Their products are sold through 2,000 retail customers in the U.S.

The "Aprica" line consists of baby strollers and high chairs. The "MCA Sports" line includes exercise cycles, rowing machines and other exercise apparatus. These products are designed and produced with the utmost regard for innovation, quality, and safety.

Presently, owners, management and employees are facing the very real threat of severe economic loss and hardship due to uncontrollable factors arising in the area of product liability. In 1984, the company's product liability insurance premium was $34,000 for $6 million in coverage (with a $1,000 deductable). In 1985 the premium increased to $60,000 for the same coverage. On the very afternoon of the renewal date this past November, Merchants was informed that its 1986 premium would exceed $295,000 (a five (5) fold increase) while the coverage would decrease to $1 million from $6 million. This represents a thirty-fold increase in cost of coverage. In addition to this increase, the policy was written on a "claims made" basis with a $10,000 per incident deductable. We've been advised that the "tail" premium will be 200% of the base or nearly $600,000. That means the cost for the $1,000,000 coverage for 1986 will approximate $900,000. We've not yet received comprehensible rationale for the predicament we face.

689 Fifth Avenue
New York, N.Y. 10022
(212) 688-3400
Telex: 710-581-6311

There is probably no single or simple cause behind this problem. The ever more frequent, sometimes frivolous product liability suits must be a major cause. For example, we have an outstanding suit exceeding $100,000 from a woman who claims a back injury after failing to tighten the seat and slipping off an exercise cycle as the seat rotated. Another suit involves an unsupervised infant, who lost the end of a finger when reaching for the chain sprocket as his older sister pedaled the exercise cycle, who asks for over $10 million.

In the juvenile industry, a settlement exceeding $10 million was awarded to the parents of an infant killed in an auto accident while riding in a car seat. The car seat manufacturer proved that the seat worked perfectly. The child's death was in fact caused by the mother being thrown on top of the child during impact. The plaintiffs prevailed on the basis that the car seat manufacturer had responsibility to warn all passengers in the car that they had to wear their seat belts to protect the child. There are many other such stories that demonstrate well the severity of the situation.

Our company was prepared to commence production of a new infant car seat which we believed would be the highest quality unit available. However, the present product liability conditions make it impossible to justify the risk to which the company would be exposed. Consequently, babies are going to be denied the advantages of our design and current and potential employees are denied a growth opportunity. If current product liability trends continue, this distasteful scenario will become all too familiar in wide spread industries and locales. It seems to us that the concept of a risk free society that denies individual responsibility and prevails upon product sources as the only appropriate remedy for injury, pain, and suffering, has no moral or rational basis. We are sure that this committee will receive many recommendations towards resolving the situation. We urge intense comprehensive study and prompt action. Your attention to and efforts in this matter are greatly appreciated.

Merchants Corporation of America

Judson M. Robert

Judson M. Robert
Executive Vice-President

JMR/ss

INTENTIONAL
BLANK

MILEX DELTA, INC.
P. O. DRAWER 5684 • SHREVEPORT, LA 71135-5684 • (318) 797-1554
919 KING PL. • SHREVEPORT, LA 71115

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Subcommittee on Oversight

COMMITTEE ON
RECEIVED
MAR - 4 1986
WAYS AND MEANS

February 25, 1986

The Honorable Daniel Rostenkowski
House of Representatives
Washington, DC 20025

Dear Representative Rostenkowski:

I have been associated with MILEX PRODUCTS INC, Chicago, IL as an exclusive franchised distributor for Louisiana and Mississippi since September 1970.

MILEX PRODUCTS INC manufactures GYNECIC products for the medical profession. We, as distributors, have been fully protected by our manufacturer's product liability insurance. They were covered by one company for over 35 years and suffered only one small claim. They were notified on February 1, 1986 that coverage was cancelled. They are now operating without product liability insurance. As you are well aware, one suit could conceivably close their doors along with the doors of their distributors.

MILEX PRODUCTS INC employs many people; distributors employ many people! Reform legislation should and must be the only solution to this dilemma being spread through the entire pharmaceutical and medical industry.

Very truly yours,

Chas E Claussen

CHAS. E. CLAUSSEN
President

CEC/gg

cc/ 1. The President
    2. The Honorable Senator Alan Dixon
    3. The Honorable Representative Buddy Roemer

MILEX DISTRIBUTORS IN CHICAGO, ILL. • GLENVIEW, ILL. • PEORIA, ILL. • LOS ANGELES, CALIF. • WEATHERFORD, TEX
CLEARWATER, FLA. • CHARLOTTE, N.C. • SHREVEPORT, LA. • FERNDALE, MICH. • MARLTON, NJ
HONOLULU, HAWAII • HATO REY, PUERTO RICO • TORONTO, ONTARIO • MANILA, PHILIPPINE ISLANDS

Statement of Phillip M. Davis
Senior Partner, Morrison, Mahoney & Miller

Representing: Bike Athletic Company,
Head Protection Companies Generally and
and Other Manufacturers Threatened by the Insurance Crisis
Precipitated by Products Liability Lawsuits

Mr. Chairman:

I have been a practicing attorney associated with Morrison, Mahoney & Miller for the past 20 years. Prior to that time, I was a claims representative with the St. Paul Insurance Company for five years while I attended law school. The majority of my practice has been devoted to the defense of product liability claims of all types. I have been associated with the defense of asbestos litigation, the Dietholstilbestrol controversy, football helmet and motorcycle litigation and a plethora of other matters.

In addition, over the past three years I have participated actively with an organization, Legal Forum International, through which I present in-plant seminars for manufacturers designed to minimize or eliminate their product liability exposure.

In the past year and a half, I have conducted numerous in-plant products seminars for companies including Coleman Industries, Litton Industries, Kelsey-Hayes, Chicago Pneumatic, E.D. Bullard, Bike Athletic Company and Corning Glass Works.

A uniform complaint of all companies is the spiraling cost of products liability insurance.

Only last week, the president of one of these companies informed me that their gross receipts are approximately $17,000,000 while their products liability insurance is approximately $600,000 for a rather limited policy with a high self-insured retention ($250,000). This is outrageous. On the one hand, if the company operates without insurance, one major lawsuit can threaten its continued existence. On the other hand, payment of these premiums requires that the company substantially raise its prices and thus lose its competitive edge particularly to inexpensive, less effective foreign imports. The $250,000 self-insured retention per incident can prove equally financially debilitating since the SIR frequently includes legal fees and expenses in addition to settlements and judgments.

There are six major contributors to this problem: sympathetic juries, the "hired gun" expert, liberal judges, the legal profession - both defense and plaintiffs' counsel, the manufacturers themselves and insurers who subrogate against products manufacturers.

I could go on at length about the role each of these contributors plays in the final inacceptably high cost of products liability insurance. Suffice it to say, it is my experience that federal intervention is necessary and that a uniform federal products liability bill must be inacted in order to preserve healthy business competition in America.

The story of William H. Brine, as related to the Commission by statement dated February 20, 1986, is an all too familiar one. His products liability insurance cost has increased 100 fold while claims against his company have remained constant. At first blush, the insurers are attempting to recoup from years of poor underwriting decisions and more recent adverse legal decisions interpreting policy language strictly against them. However, over the past five or ten years, insurance stocks have out performed the market substantially. They are now and always have been a solid growth investment. This contradicts the argument that insurers are losing money and must raise premiums drastically.

Bike Athletic Company manufactures football helmets. These helmets are worn by over half a million youngsters, high school, college and professional athletes each Fall. They protect the wearer from hundreds, if not thousands, of impacts over the course of a season. However, statistically, one can predict that perhaps 10-20 unfortunate football players will suffer catastrophic cervical spinal injuries or serious brain injuries in the course of a football season. The football helmet cannot protect against neck injuries, yet helmet manufacturers are sued for many millions of dollars each year and required to defend cases at a great legal expense. Likewise, it is impossible to design a functional helmet which will protect the wearer from all impacts leading to serious brain injury. Yet the lawsuits continue presenting an unmanageable cost to head protection insurers both legally and insurance wise.

I recognize that the solution is complex. However, companies cannot continue to spend substantial sums defending cases, settling claims and paying experts and attorneys to defend them. Just the threat of the involvement in a products suit forces settlements of numerous groundless claims. This in turn precipitates higher insurance costs pushing the system further out of control.

Punitive damages place another substantial burden upon manufacturers and in most jurisdictions such awards are uninsurable.

The threat of litigation forces manufacturers into a defensive research and development philosophy. It dampens the enthusiasm for new or innovative medicines, safety devices or other products whose unequivocal benefits may come under attack in the courts. Indeed, it is the items most needed, safety equipment, which are now the most expensive. They are, in theory, the last line of defense which protects the user from injury by the product. Most importantly, insurers view these and other vital products as presenting the greatest risk to their company. Hence, they raise the premium substantially for companies providing the most critical products and actually force some manufacturers to discontinue these products and shift to more innocuous products with lower premiums.

Psychologically, corporate America is reeling under the blows delivered by various courts and the insurance industry. I unequivocally endorse the approach of Senators Kasten and Danforth in their efforts to develop a system of compensation which treats the victim of a product related accident fairly and uniformly. Without relief, I fear for the future of many small and intermediate companies manufacturing products necessary for our society today.

NATIONAL ASSOCIATION OF INSURANCE BROKERS
1401 New York Avenue, N.W. • Suite 720 • Washington, D.C. 20005 • Telephone (202) 628-6700

STATEMENT SUBMITTED BY ROBERT H. MOORE
ON BEHALF OF THE
NATIONAL ASSOCIATION OF INSURANCE BROKERS
April 28, 1986

Subcommittee on Oversight
Committee on Ways and Means
U.S. House of Representatives

Mr. Chairman, the National Association of Insurance Brokers (NAIB) requests that this statement be made part of the printed record of the Subcommittee on Oversight's hearing on the Cost and Availability of Liability Insurance.

The NAIB is the trade association of commercial insurance brokers. Founded in 1934, our members range in size from large international companies to regional and local firms. We provide insurance and risk management services to clients in the United States and around the world. In 1985, NAIB members administered over $30 billion in premiums.

As the 1985-86 NAIB president, I represented our association at a public forum sponsored by The New England Council in Stamford, Connecticut on April 23. The title of the forum was "The Liability Insurance Crisis: Problems and Options." We believe that our remarks to this group of New England business leaders are particularly germane to the subject of your hearing and we are submitting a summary of these remarks today:

Coalition Building: A Constructive Response to The Liability Crisis

> The NAIB believes that solutions to the country's liability crisis are inexorably tied to coalitions of Americans acting in their shared self-interest.
>
> The country's current dilemma of available and appropriate insurance coverage at affordable prices is the result of a combination of complex and interrelated forces. The necessary remedies are not likely to be implemented on a widespread basis until 1987 at the earliest. And even then, remedies will not be forthcoming without the concerted efforts of a broad cross-section of business and professional groups, state and local governments, the insurance industry and nonprofit organizations.
>
> From my experience as an executive of Alexander & Alexander and a member of the U.S. Chamber of Commerce's Civil Justice Action Group, I can testify that this group is a prototype of the kind of coalition building that America needs. Its members include representatives from such diverse organizations as the National School Boards Association, Illinois Manufacturers' Association and The American Red Cross.

Coalitions such as the Chamber group need to marshall their efforts behind such initiatives as:

* Working for meaningful tort reform at the state and federal levels. The American Tort Reform Association is a nonprofit coalition which is deserving of widespread support.

* Demonstrating that tort reform is consistent with the principle that those who are wrongfully harmed often deserve to be fully compensated.

* Advocating that insurance companies respond to tort reform by moderating their escalating pricing practices.

* Working for the expansion of the Product Liability Risk Retention Act of 1981 to allow professionally managed and financially viable risk retention groups to cover general liability risks.

* Communicating the economic realities of property and casualty insurance to the widest possible constituency. In May the NAIB will be publishing Commercial Insurance: Basics of the Business to assist policymakers and the general public to better understand the complex dynamics of today's insurance crisis.

* Supporting the risk management movement so Americans will be increasingly well-informed about their financial exposures and their options for managing them.

Statement by the

NATIONAL ASSOCIATION OF PROFESSIONAL INSURANCE AGENTS

Mr. Chairman and Members of the Subcommittee on Oversight, this statement is submitted on the insurance availability crisis by the National ASsociation of Professional Insurance Agents (PIA).

PIA has more than 42,000 members. They are independent insurance agents and brokers located throughout the 50 states, Puerto Rico, the Virgin Islands and Guam. PIA members service all lines of insurance but have special expertise in the property/casualty side of the business. As independent small business owners, with an average of five employees, they represent several insurance companies and have access to a greater number of insuring markets through brokerage agreements.

As independent agents, we have a legally recognized right to the renewals of the business we produce. This right belongs to the agent. Our clients are always free to choose their company and agent at any point. The worth of our agency as a business is based primarily upon the assessed value of our renewal book of business. Therefore, while we may be a licensed agent for this company or that, our allegiance to our client is very strong. Company-agent relations may come and go, but we take great care to continually build and service our clientele.

This unique characteristic of the American Agency System gives independent agents and brokers a unique perspective. We listen to and understand the concerns and needs of our clients. We share these real-world conditions with our companies so that sensible responses can be made. Conversely, it is our responsibility to take complex and highly technical insurance matters and make them clear and understandable to our customers.

This responsibility has been placed to the supreme test during the current market conditions.

The Types of Markets:

Insurance companies and their rating organizations can provide the Committee with great detail on how the insurance market arrived at this point. However, we believe an abbreviated version from our viewpoint might be helpful in placing this into perspective. To do so, we will define capacity, describe the three basic insurance markets and how they interrelate.

Capacity:

Capacity is the ability (in dollars) of the insurance industry to insure the dollar levels of insurance the marketplace requests. There is a limit to the amount of premiums an insurer can write according to the statutory accounting rules. The limit for a given insurer is a function of its premiums to surplus. When an insurance company approaches its capacity limit, it may be necessary to allocate the available capacity across the various lines and territories which makes up the book of business. This causes a restriction in the insurance market for less desireable risks. The more dollars available in the industry, the more coverage it can handle. Capacity exists at every underwriting level. Each insurer and each of the following market segments has its own capacity. The aggregate of these comprises the total industry's capacity.

Primary Market:

This is the first layer market that provides the majority of insurance for most commercial coverage needs. Businesses seek to find coverage in this market first. It consists mostly of U.S. domestic companies that are licensed and admitted to do business in one or more states. With some exceptions, the kinds of risks insured, the coverages offered, and the limits of liability secured are generally of a standard nature.

Excess/Surplus Lines (E&S) Market:

This is the first level of the specialty market. Clients that need more coverage than the primary market will offer, or which require specialized coverages for the unique nature of the risk being insured, seek coverage here. The E&S market may also work in combination with a primary market policy to provide what we call a "layering" of coverage. This market is composed mainly of U.S. companies, but has a healthy mix of foreign companies who do business in this country. E&S companies are licensed to do business in their state of domicile. Generally, they are allowed to operate in other states on what is known as a "non-admitted" basis. This allows greater freedom in the rates charged, and the wording of the specific coverages being offered. The E&S market provides innovation, creativity and elasticity that the industry needs to cover the insurance requirements of new and unique businesses as well as providing higher limits of liability so necessary in today's litigious society.

Reinsurance:

At times, companies in this market can act as a primary insurer for those lines of business or specific accounts that cannot be accommodated in either the primary or E&S markets. However, the major purpose of this market is to insure insurance. Most of the customers of this market are insurance companies. Reinsurance provides primary insurers with additional capacity to underwrite risks as it frees some of their capacity for other uses. Most times in negotiating with the reinsurer, the originating insurance company decides what level of limits from a book of business it will absorb and the balance is covered by the reinsurer. Come clients may choose to self-insure the exposures and limits of coverage that would normally be absorbed by the primary insurance market. Companies from the reinsurance market reinsure the balance to protect against the catastrophe loss. Most reinsurers are foreign but the number of domestic companies has been growing.

While there are variations on these themes, these are the main components. The health of each market segment affects the health of the other. If the primary market constricts, more business will be forced into the E&S market, and possibly the reinsurance market. This may mean higher prices and changes in coverage but desired limits of coverage may still be available.

When capacity shrinks at the reinsurance level, the pressure is felt down the line. Fewer clients can be accommodated; or requested limits of coverage cannot be fully secured. Premiums will increase. Lines of insurance considered marginal may not be written at all. Business is considered marginal because of inadequate actuarial data, or because rapidly evolving court decisions have made accurate pricing of the risk impossible. The current market has both elements.

How We Got Here:

In the late 1970s, a number of new reinsurance companies were formed, and an influx of capital came into the reinsurance marketplace. This provided almost instant capacity. The primary market was recovering from a capacity shortage it faced in the early to mid 1970s. The greater the capacity, the more coverage you can write, both in limits and the kinds of risks. Competition was keen. Interest rates were high, creating an incentive for insurance companies to lower premium rates to generate cash flow for investment purposes.

These economic factors were being felt at the primary insurance level as well. Commercial risk insurers wanted to generate premium dollars up front so that they too could take advantage of the high yield interest rates. Some commercial clients moved towards self-insurance adding an additional element of competition for insurers. In response to the competitive demands of the commercial insurance market and to counter a loss of market share, insurers kept offering lower prices and more coverage. Some even ventured into new lines of insurance, most notably in the pollution liability area. Once in motion, the cycle fed on itself, fueled by the economics of the time. Soon, interest earnings leveled off and then began to decline. The cash flow investment gravy train was over.

Another important side of this dilemma is the loss picture. The loss experience finally surpassed the industry's ability to attract capital, and to use investment income to make up shortfalls between the price charged and the loss incurred. Insurers had to return to underwriting on a profitable basis by: charging sufficient premiums to cover the risk; withdrawing from markets with unacceptable/unpredictability; reestablish underwriting standards/risk analysis; and in some cases withdraw from the market until the financial conditions of the insurer settled/recovered. On this later issue in 1985 some 45 companies withdrew from the entire marketplace involuntarily by going insolvent. (Statistics from the National Association of Insurance Commissioners).

In addition to rate inadequacy, there were undeniable trends developing in the litigation area.

Pollution Exposures:
The most notable and far-reaching involved pollution exposures. We are only beginning to understand the nature of various pollution situations and the resulting liability exposure. This exposure is generated from three areas . . . pollution exposures knowingly insured but whose potential loss was underestimated; risks now found to have a pollution exposure which were unknown at the time they were insured; and pollution exposures the industry thought it had excluded by policy provisions but have been held to be covered by the courts.

Liquor liability:
Another area where notable change took place was liquor law liability. A number of court cases were involved affecting saloon keepers, bartenders, companies serving alcohol at employee functions, and even private citizens hosting parties. The courts held these persons to varying degrees of liability for the bodily injury and/or property damage subsequently caused by those who had over-imbibed. This has substantially increased the nature of the risk for liquor law liability insurance.

Sovereign Immunity:
The erosion of sovereign immunity continues at all levels of government. The federal government recognizes this situation and has formed a special task force headed by the Justice Department to address the issue of tort law reform, and the federal government's exposure. Municipalities and states have also been hit hard.

Product and Professional Liability:
Product liability and medical malpractice problems, which first hit the headlines in the 1970s, never went away.. Again, these lines are in the news because of tight insurance markets and rising costs. Product liability tort reform is still not a reality, and doctors continue to be held to higher degrees of liability.

Because, the nature of these and other previously insured risks are changing so rapidly, past loss experience can no longer apply. Additionally new court decisions continually add new elements to it. Under these conditions, calculating accurate rates is far too imprecise. The industry is at a loss to deal with them. Add to this, a lack of overall capacity and the ability to respond is either greatly reduced or eliminated.

The end result is that we have basically two market problems. First, there is the pressure caused by a lack of capacity. Time and capital infusion will arrest this dislocation. Second, market pressures exist that result from an inability of this industry to properly apply its trade (actuarial principles) to ascertain the nature and cost of certain exposures. For these risks, capacity recovery alone will not help. There must be at least two additional changes. One is tort reform to set reasonable boundaries and restore predictability to recovery. And second, there must be some appropriate government enforcement of existing regulatory and legislative oversight of activities such as waste sites permitting the elimination of undesirable players.

What Can/Is Being Done:

A return to the sound underwriting principles will nurture recovery and help restore a stable market. PIA firmly believes that these tools can provide a fair and stable market for most commercial clients. Bargain basement premiums are hard to resist, but they lead to significant adverse adjustments in the availability and affordability of insurance every few years. The business community would do well to opt for steady, gradual price increases instead.

The client's right to a stable market can also be improved by placing state regulatory controls on midterm cancellations of policies and/or midterm premium increases. In October 1985, PIA adopted policy positions regarding these issues. In brief, we believe that midterm premium increases are wholly unjustified unless there has been some change in the risk. After being in effect for 60 days, a policy should not be cancelled midterm unless there is a material change to the risk that would render it uninsurable and/or unless facts come to light that were unknown when the risk was written that would have materially affected the initial underwriting decisions. Non-payment of premiums would be a legitimate reason for midterm cancellation, it should be discussed with the state insurance regulator, and an orderly plan of action developed.

The time given for a notice of cancellation and nonrenewal is important too. PIA's positions suggest no less than a 30-day notice. We recognize that there may be cases where an insurer may wish to expedite these notices. Such exception should be discusses with the state insurance commissioner.

When and how a renewal quote is delivered affects the client's rights and the duty of agents and brokers to shop the market. We have recommended how this should be accomplished, and that the quotation should specify any change in the insuring agreement.

Ideally, these standards would be met voluntarily. However, most of the insurance industry concedes that some degree of mandation is necessary. To this end, PIA is working with the National Association of Insurance Commissioners (NAIC), individual companies, insurance trade associations, and state legislators. The level of cooperation from all parties is good.

Resolution may be achieved by the end of the states' 1986 legislative session.

PIA, along with other members of the industry, are creating Market Assistance Programs (MAPS). There are three levels to MAP's:

- Market Analysis, which can uncover trends and problems,
- Information Hot Lines, which can be used by agents or consumers to inquire about whether coverage for their account can be placed and where, and
- Formalized MAP structures for identifying markets, and the placement of business within them.

How the MAP concept works is simple. Some degree of market dislocation occurs because an agent may have lost his particular market. This agent may be unaware of an agent or broker who may have an open market for the business. Once this market is identified, the agent can arrange a brokerage agreement with the insurance producer or company that does have the market.

To assist PIA's state/regional affiliates in designing programs along these lines, PIA has just concluded our Annual National State Legislative Conference. The issues of, and solutions for, insurance availability/affordability were the main focus.

Tough markets challenge and bring to the forefront the creativity of agents and brokers in structuring insurance arrangements that meet the needs of their clients. In addition to piecing various levels of insurance together, agents and brokers are exploring self-insurance and captive insurance companies with their clients. These methods are not for all clients but alternative insuring mechanisms are here to stay. PIA believes that traditional insurance is the best approach. However, when that can't be achieved, we assist our clients in either structuring their own program, or placing them in an existing group. This demands a great deal of expertise on the part of the agent and broker, but developing new approaches is a basic requirement of our business. PIA sponsored a seminar on captives in February for our members to learn how they operate.

Currently, Congress is considering several bills to broaden the Product Liability Risk Retention Act of 1981 to cover all commercial liability insurance lines except workers compensation and employers liability. PIA believes that the state insurance commissioner's ability to adequately regulate these groups for financial soundness and fair market practices must be provided in these measures. Therefore, we support the concepts embodied in the National Association of Insurance Commissioners package of amendments to S.2129, the Risk Retention Amendments of 1986. These improvements must be contained in any legislation adopted by Congress on this issue. PIA also notes that expansion of the Risk Retention Act is not the answer to most commercial clients availability/affordability insurance problems.

The Long-Term Solutions:

Not all market problems will disappear with the introduction of more capacity. Reform of the problems that exist in the civil justice system must take place. This is where Congress can show leadership and effect change. PIA, as are many others, is involved in a number of efforts. We have joined with our clients' trade groups in seeking a fair and equitable resolution.

PIA supports the review and possible decrease of the limits in mandated financial responsibility (FR) laws. FR limits are not a cap on liability, nor do tortfeasors avoid having their business or personal assets placed at risk if the injury/damage is great enough. In some instances, government views FR limits as a device to make the insurance industry a quasi-regulator. This is an inappropriate role for the private sector, and one this industry doesn't want. It places an artificial pressure on insurance capacity. There are only so many dollars to go around, and if insureds are forced by government to purchase higher and higher limits which may bear little relationship to their own individual exposure then there will be fewer and fewer customers the insurance industry can accommodate.

This is apparent in the Motor Carrier Act of 1980. PIA heard of market problems as early as April 1984, from agents/brokers who specialize in the field. This was reported in the May 1984 issue of our magazine, PROFESSIONAL AGENT.

Additionally, we brought this to the attention of Congress in our several hearing appearances. Congress should review all federal laws which impose FR limits.

Another long-term solution involves changes in insurance policy contracts. This is the cleanest and quickest way for the industry to alleviate problems in risks with long-tail exposure and/or sensitivity to changing legal interpretations.

Much has been written about the introduction of the new Commercial General Liability (CGL) policy, both the occurrence, and the new claims-made forms. PIA believes the recent changes the Insurance Services Office (ISO), an industry rating organization, has made in developing the CGL program will help reduce current market dislocations. This program will be perfected as market experience develops. Without this program, market problems will be exacerbated.

PIA worked closely with ISO in suggesting improvements to the program. The NAIC has done extensive work in furthering those improvements. It is our hope that insurance regulators will now find the package of policy changes acceptable.

Insurance Oversight:
PIA has a long-standing commitment to the state regulation of insurance. We believe it serves the consumer best in that it can respond to problems more quickly and precisely than can the federal government. It has served the public very well. The NAIC is developing the technology and talent to keep improving the standard of state regulations.

Company Solvency/Reinsurance:
The current system of insurance company insolvency protection has served insurance consumers well. However, the industry recognizes updating is needed. A number of proposals for change have surfaced in the last two years. PIA adopted a revised/updated position on these issues at its National Board of Directors Meeting, February 25, 1986. The major points that we support are:

- the establishment of guaranty funds for both property casualty, and life/health insurance in all states for claims and unearned premium return (P/C funds for claims are established in all states); and
- each P/C claims funds should have a minimum limit of $300,000 liability coverage.

Conclusion:
The cause of this market cycle is not singular. Short-term solutions will not be effective. The long-term resolutions require a commitment to act, and the involvement of all affected parties.

PIA believes that the focus Congress is placing on this issue is healthy. It heightens the sense of commitment to resolve these problems by those who wish to preserve the McCarran-Ferguson Act. Also, Congress can more clearly identify what role it should/could play.

Congress can best serve as a leader in exploring long-term tort solutions particularly for federal statutes/regulations.

STATEMENT OF
NATIONAL ASSOCIATION OF RECYCLING INDUSTRIES, INC.

The National Association of Recycling Industries, Inc. (NARI), the trade association for the nation's metals, paper and textile recycling industries, submits this statement for the record in response to the subcommittee's notice of hearings dated February 26, 1986.

Introduction

NARI's membership consists of approximately 1,000 firms located throughout the United States, all of which are engaged in either domestic industrial recycling or foreign trade recycling activities, or both. During 1985, the metal recycling segment of NARI's membership produced 45% of the nation's copper raw material supply, 35% of its aluminum, 48% of its lead, 18% of its zinc, 30% of its iron and steel and 47% of its stainless steel. Simultaneously, the U.S. recycling industry exported millions of tons of critically important metal scrap, wastepaper and textiles to our trading partners abroad.

As the subcommittee undoubtedly knows, Congress has repeatedly declared that industrial recycling is in the national interest, and that consequently the Government should act where necessary and appropriate to expand its markets and operations.1/ Industrial recycling conserves energy and depletable natural resources; reduces hazardous waste disposal as well as industrial air and water pollution; alleviates our nation's reliance on foreign raw material supplies, and beneficially impacts our balance of trade and balance of payments positions, which in recent years have been precarious indeed.

Unfortunately, however, since 1982 the national recycling industry has experienced a severe economic depression, and currently no recovery is in sight. The industry has been plagued by bankruptcies, plant closings and mergers at a rate higher than at any previous time in the last 75 years. Indeed, the metal recycling industry has contracted by approximately 20% since 1982.

1/ Resource Conservation and Recovery Act of 1976, as amended, 42 U.S.C. 6901(c), 6902(8); 42 U.S.C. 6951-6962.

Liability Insurance Crisis In The Recycling Industry: Created In Major Part By The Federal Government Itself.

During the last two years, an additional economic hardship of almost unbelievable proportions has been added in the form of a liability insurance crisis. Liability insurance premiums for metal recyclers, for example, have increased as much as 700% in cases where insurance is still available, while some companies have been forced to operate without any insurance at all.

The insurance crisis confronting the recycling industry differs dramatically from that experienced by most other segments of the economy in one major respect: Contrary to the sense and purpose of the aforesaid Congressional directives that the Federal Government develop new markets for recyclable materials and eliminate unnecessary federal impediments to maximum industrial recycling, federal agencies such as the Environmental Protection Agency (EPA) and the Occupational Safety and Health Administration (OSHA) have sought, and are continuing to seek, to classify plainly nonhazardous recyclables such as recycled aluminum, copper and steel articles and scrap, as "hazardous", and thereby subject those nonhazardous materials to all of the costly, fear-producing regulatory regimes applicable to hazardous materials.

In order to make beneficial recycling activities subject to its hazardous waste regulations under the Resource Conservation and Recovery Act (RCRA), EPA actually had to adopt a brand new rule which defines the basic term "solid waste" to include marketable recyclable commodities that have already been reclaimed from the solid waste stream. In this regard, EPA's extremely complicated definition seems diametrically to conflict with the very simple definition of that same term as prescribed by Congress in RCRA itself. In response to NARI's opposition, EPA finally agreed to exempt recycled "scrap metal" from said definition —and thus from the scope of hazardous waste regulations designed for hazardous chemical wastes. However, other readily marketable recycled metal commodities are still subject to this new EPA regulation, and thus, unlike exempt scrap, they are treated as "hazardous waste" for purposes of transportation, insurance, exportation and handling. The result for U.S. metal recyclers: Transportation and handling costs for these materials have skyrocketed, and their liability insurance has been cancelled in many instances.

One such regulated commodity, of course, is the recycled automobile battery. Recycled batteries are treated as "hazardous" under EPA's new RCRA definition of "solid waste", so battery recyclers must be licensed by EPA in order to transport, store or engage in other recycling activities. The result for battery recycling in the United States: The battery recycling rates declined from 95% to 68%; recycled battery prices fell from 13.5¢ per lb. to 4¢; five (5) secondary lead smelting plants closed in 1985 alone; and huge tonnages of batteries previously recycled are being dumped for government disposal! As the attached excerpt from the American Metal Market for March 28, 1986 indicates, EPA is now conducting an investigation to determine whether its entire regulatory program for recycled batteries should be revamped. One EPA official is quoted as stating EPA must find ways "to get those batteries recycled".

But, while EPA is now confronted with the self-defeating results of its ill-conceived extension of its hazardous waste regulatory controls to nonhazardous beneficial recycling activities, OSHA has involved all metal scrap, including recycled cans, automobiles etc., in its definition of "chemicals" under the Hazard Communication Rule. Also, certain rules heretofore applicable exclusively to manufacturers —smelters, refiners and chemical distributors— whose employees OSHA believes are possibly subjected to toxic chemical fumes and dust in the course of their production activities, have now been proposed by OSHA for extension to all firms simply engaged in the processing of nonhazardous scrap metals. In this form, scrap is no different than it is in our individual hands in our own households! Here again, therefore, a federal agency is seeking to stigmatize normally nonhazardous recycled metals as hazardous when recycled by scrap dealers, brokers and processors in the very first step of the recycling process —that is, before they even arrive at a smelter or refinery and are converted to a raw material again through a melting process.

It is truly ironic —and a gross contradiction to the national interest— that the very recycling activities which preclude and prevent waste from entering the disposal stream are the victims of unwarranted, ill-conceived and counter-productive federal regulations that themselves have compounded an urgently serious liability insurance crisis.

NARI is opposing this overzealous, overregulation of essentially nonhazardous recycling activities. But, unfortunately, the economic damage to beneficial recycling has already been done: Scrap dealers, brokers and processors have already been confronted, and continue each day to face, skyrocketing operating costs, heavy, new compliance costs, and the total loss of liability insurance coverage, simply because the Federal Government fallaciously proposed to define the recycled metals they handle as "hazardous chemicals".

The Solution In The Recycling Industry

NARI thus submits the Federal Government should devise a liability insurance solution that will specially alleviate conditions in the national recycling industry for the following cogent reasons:

1. The Federal Government is statutorily committed to adopt programs that promote maximum industrial recycling and remove needless self-defeating federal impediments to recycling.

2. The Federal Government, through EPA and OSHA, has actually created much of the liability insurance crisis in the recycling industry by needlessly stigmatizing nonhazardous recycled metals as "hazardous waste" and "hazardous chemicals", without any specific or direct statutory authorization from Congress.

3. The Federal Government alone can "roll back" these exceedingly damaging EPA and OSHA actions, and reestablish, for insurance purposes, that normally recycled metal articles and metal scrap are nonhazardous in that form, and thus should qualify for insurance and insurance rates applicable to nonhazardous materials, rather than to hazardous wastes or chemicals.

4. Congress should adopt legislation which establishes maximum reasonable insurance rates for those engaged in beneficial recycling activities that are in the national interest, with the creation of a guaranteed available minimum amount of liability insurance, on reasonable terms and conditions, for those engaged in recycling activities. Such recycling activities actually reduce and minimize potential hazardous waste and pollution exposure, and therefore it is in the national interest to provide for such a guaranteed insurance availability.

5. Finally, of course, the recycling industry, like a number of other segments of the American economy, urges the President and Congress to take other actions that will alleviate the overall insurance crisis

confronting the nation. The Domestic Policy Council's recommendations to the President dated March 14, 1986 should certainly be fully considered, especially the one aimed at establishing a uniform standard of product liability for all manufacturers.

Proposals for the creation of a federal insurance commission, and for more effective controls over insurance rates and practices, especially as they impact firms engaged in critically important recycling activities, are surely in the national interest at this time. Some fair limits should be imposed on the type and amounts of liability exposure confronting businessmen throughout the United States, along with reasonable restrictions on the amount of attorneys' fees which are recoverable in liability litigations.

* * *

In conclusion, NARI wishes to thank the subcommittee for conducting these important oversight hearings, and for permitting us to submit this statement to direct your attention to the unique aspects of the liability insurance crisis in the national recycling industry.

Respectfully Submitted,

NATIONAL ASSOCIATION OF RECYCLING
INDUSTRIES, INC.

By:
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Washington Counsel
6000 Connecticut Avenue, N.W.
Washington, D.C. 20815
Telephone: 656-0210

April 18, 1986

American Metal Market
3/28/86

Unrecycled Batteries Under Investigation; EPA Report Due

By BILL SCHMITT

WASHINGTON—Amid complaints from the secondary lead industry that government regulation is weakening and is causing a decline in battery recycling, the Environmental Protection Agency is studying whether the decline itself now needs the regulator's attention.

The Environmental Protection Agency currently is funding a consultant's study of unrecycled batteries, and a preliminary report, which could pave the way for further EPA analysis and action, is expected next month, according to Glen Anderson in the agency's Office of Policy, Planning and Evaluation.

He said the study is looking into these questions:

- How many lead acid batteries are being recycled and has this number declined substantially in recent months?
- What is happening to the unrecycled batteries? Are they being dumped in municipal landfills, for example?
- Are the unrecycled batteries posing a significant threat to the public health?

An EPA ruling classifying spent batteries as hazardous waste went into effect in July 1985. Another regulation requiring battery breakers to be an EPA-licensed T.S.D. facility which refers to transportation, storage and disposal went into effect in November 1985.

Meanwhile, an environmental specialist in the secondary lead industry says there is no doubt that "the recycling chain is breaking down," and he says he will be asking the industry itself to raise public awareness about the problem.

(Continued on page 8)

Pg. 2 cont'd

(Continued from first page)

John A. Bitler, vice president of environmental resources at General Battery Corp., Reading, Pa., and an environmental subcommittee chairman for the Battery Council International, said he plans to raise the issue at the council's April 6-9 meeting in Maui, Hawaii.

Awareness Program

He said he expects that meeting to be "the real kickoff" of an industrywide "awareness program" aimed at alerting Congress to the regulatory and market pressures faced by secondary smelters.

One very tangible sign of those pressures is the decline in the number of U.S. secondary lead smelters from 44 last year to 25 today, Bitler said. The explanations for such shrinkage stem from both market trends and federal environmental regulations, he said. And the regulatory burdens make it especially difficult for the smelters to function in the current environment of low lead prices.

That raises the possibility, Bitler said, that batteries "are going to end up in landfills, they're going to be disposed of improperly."

The price of primary lead has remained very low—hovering around 18 cents per pound currently—and has forced down secondary lead prices. Secondary smelters bring in too little money either to make a profit or to offer sufficient incentives to attract used batteries for feedstock, he said.

"At 18 cents a pound, you can't collect as many batteries," commented Kenneth Wise, a lead expert at the Cambridge, Mass., management consulting firm that is doing the EPA-funded study.

"A lot of people thought the lead price was going to go up again and solve this problem," Wise said, but now there are signs that lead prices are unlikely to strengthen to the levels they attained several years ago—averaging as high as 53 cents per pound in 1979.

Wise agrees that it appears "the regulations have hurt a number of people in their (the secondary smelting) industry." He said the regulations affecting the smelters include air and water emission standards, storage and handling requirements under the Resource Conservation and Recovery Act, and workplace rules from the Occupational Safety and Health Administration.

Percentage Falls

The bottom line is that fewer batteries are being recycled, Wise said. Historically, up to 90 percent of all automobile batteries were recycled, but now it is possible the percentage has fallen as low as 65-70 percent, he said.

Where these unrecycled batteries go—and, the possible impacts they have after disposal—are among the issue being looked at in the study. It is possible that more un-recycled batteries are being dumped in municipal landfills, where the batteries' lead content could leach out into the surrounding environment, Wise said.

One way the study is tackling this question is by looking at landfill sites that have been slated as priority cleanup sites under the federal Superfund program, Wise said. There, studies have already been done regarding the presence of various substances.

But Wise and Anderson agreed that much more study would have to be done beyond the work in this preliminary study before the agency could define a particular problem and its solutions.

Anderson stressed that the future direction of any EPA review of battery recycling is unclear. He called the current study "a very modest effort" that is simply asking, "Is this a problem that we should worry about?"

He said a decision would have to be made within EPA, based on next month's preliminary report, on whether to go ahead with more extensive and expensive probes of lead battery disposal and its possible effects on health.

If an environmental problem is proven, the EPA might study ways "to get those batteries recycled," Anderson said. He said the alternatives that could be considered range from direct regulation to "incentives" for recycling, such as a variation on the cash-deposit program now used with returnable bottles and cans.

Rely on Incentives

"We're going to have to rely more on incentives than on regulations" should any kind of corrective policy be needed, one EPA source said. "Enforcement's almost impossible."

According to Ritler, the fact that the EPA is looking into battery recycling problems is good news in itself. He said the "awareness program" he hopes to spearhead is aimed first at bringing the industry together on the issue and then at alerting legislators to the industry's need for help.

Referring to the EPA study, Bitler said, "I think this is the kind of message we need to get across."

[redacted]

[redacted]

OVER 60 YEARS OF SERVICE TO INDIVIDUALS WITH DISABILITIES

Office of Governmental Affairs

April 2, 1986

The Honorable J. J. Pickle
Chairman, Subcommittee on
Oversight
Committee on Ways and Means
U. S. House of Representatives
1105 Longworth House
Office Building
Washington, DC 20515

RECEIVED
APR 18 1986
Ways and Means
Subcommittee on Oversight

Dear Mr. Chairman:

I am writing with regard to the recent hearings that your Subcommittee on Oversight held to examine the costs and availability of liability insurance. Please include our statement in the hearing record on this subject.

The National Easter Seal Society is the nation's oldest and largest voluntary organization providing direct services to persons with disabilities. Founded in 1919, the Society is universally recognized as the pioneer in the provision of rehabilitation services to persons with disabilities.

During 1985, Easter Seals served over one million individuals. Our programs benefitted people in every state in the United States, Puerto Rico and the District of Columbia. Our organization now provides services to one out of every 240 Americans.

The needs of individuals who have disabilities vary greatly. Services provided by Easter Seal Societies to meet those needs include: physical, occupational and speech-language therapies, vocational evaluation and training, camping and recreation and psychological counseling, equipment loan and purchase, and respite care. Health screening programs for potentially disabling conditions are also sponsored by Easter Seals. Individuals of all ages, having disabilities from any cause, can find assistance through Easter Seal programs.

Because we operate so many different programs, our affiliates need adequate liability insurance. During the past year, state and local Easter Seal Societies have experienced many of the same problems encountered by business, government and other nonprofit agencies in securing adequate coverage. Many of our affiliates have found that liability coverage is either prohibitively expensive or extremely difficult to secure.

The problem has become so serious that some of our programs are in jeopardy. We have had a particularly difficult time getting adequate insurance in four program areas: camping, transportation, residential and day care. There are unavoidable risks in providing services in these areas and our affiliates must be protected if they are to continue their efforts.

In many communities, we are providing government-financed services. We provide services funded by a broad cross section of federal programs including, but not limited to: Medicare, Title XX, State Grants for Vocational Rehabilitation, Medicaid, State Grants for Education of the Handicapped, the Maternal and Child Health Block Grant and the Projects With Industry Program under the Rehabilitation Act.

In your own Congressional District, the Capital Area Easter Seal Rehabilitation Center of Austin, Texas has experienced a great deal of difficulty recently in obtaining liability insurance. The Center provides a broad array of services including occupational, speech and physical therapy, computer camping, outpatient therapy for children, respite care and equipment loan. On January 29, 1986, the Rehabilitation Center had to suspend operations for the entire day because of their inability to secure coverage. On March 21, 1986, the Center obtained an umbrella policy, but only after nine out of the eleven companies solicited by the broker rejected the facility's request for insurance. Once insurance was obtained, the cost for professional liability increased by over 1,000% and the cost for bus insurance rose by over 300%. Obviously, these increases cannot be passed on to our clients because most of them cannot afford to pay.

Lila Coughran, the Center Director in Austin, is willing to elaborate on their insurance problems. You may contact her directly for futher information at the Capital Area Easter Seal Rehabilitation Center; 919 West 28 1/2 Street; Austin, Texas 75235. She is also surveying other Easter Seal facilities in Texas on this subject with the intention of submitting a statement to the Texas Legislature.

We commend you for your willingness to examine this issue. We urge you and your colleagues to seek an expeditious solution to this problem which affects so many aspects of our economy.

Sincerely,

Joseph D. Romer

Joseph D. Romer
Director of Governmental
Affairs

JDR:cg

TESTIMONY OF

CONGRESSMAN JOHN E. PORTER

(ILLINOIS)

ACTIONS TO CONTROL MEDICAL LIABILITY PROBLEMS

Mr. Chairman, I welcome the opportunity to bring to the attention of this subcommittee the continuing serious effects of the liability insurance crisis on the cost and availability of medical care. Last week the Chairman of the Health Subcommittee of the Ways and Means Committee, Mr. Stark, and I introduced House Resolution 386 calling on the States to enact certain reforms to improve both cost control and quality control in medical services. A copy of that resolution is attached to these remarks. We welcome other Members to join the growing bipartisan list of cosponsors of the resolution who are sending the important message to the States that they must act at once to tackle this problem.

This resolution grew out of concern that society is being ill-served by our present unpredictable, expensive, and time-consuming method of redressing medical injuries. Increasingly people are trying to use the courts as a channel to challenge bad medical results and secure a financial settlement, even when negligence is not an issue.

Escalating costs of malpractice insurance and withdrawal of commercial insurers from the marketplace for malpractice insurance in a number of states were the first manifestations of a nationwide crisis in the mid-1970s. One result of that earlier crisis is that most of the medical malpractice insurance in the country today is essentially pooled self-insurance. Doctors and other providers are now assessing themselves for their malpractice premiums in many states through mutual liability companies. Escalating insurance costs are not simply the fault of "greedy" insurers in these circumstances, though the crisis is sometimes misrepresented that way.

Even with various forms of self-insurance, liability-related costs do continue to escalate and are a major underlying factor in rising health care costs and in other serious damage to our health care delivery system. While the few bad doctors have been insufficiently monitored and controlled -- a need which our resolution addresses at length -- the many good doctors and their patients are becoming increasingly scared of each other. Doctors respond to the higher chance of being sued by dropping out of high-risk specialities like obstetrics, by avoiding the difficult cases where their skills are most needed, and by ordering more and more tests to back up their judgments. Patients cannot find proper care and the rising costs of a visit to a doctor or hospital frighten away many from even seeking care.

These rising costs are clearly hurting the Federal budget, which pays 30 percent of the $400 billion annual health care costs nationwide, and the state and local governments which pay another 10 percent. At least one percent of the health care costs are directly attributable to malpractice premiums and related costs, with an estimated additional three to ten percent being paid for "insurance" in the form of defensive medicine of questionable cost effectiveness.

Equally serious is the fact that victims of true malpractice are losing their ability to recover damages because the unpredictability of the legal system may dry up liability insurance. If doctors and hospitals cannot get insurance or if their insurance companies go broke, then victims' legal rights to compensation do not mean much in practice. There is a danger that the money to pay their claims will not be there, even if they win the case.

A year ago I commissioned a series of research studies on the medical malpractice crisis by the General Accounting Office. The first report in the series of five has just been released. It gives the views of national organizations of doctors, lawyers, insurers, and consumers. Not surprisingly, they disagree on where the main fault for the malpractice crisis lies. Each group tends to blame the others for the worst problems. However, they do agree on one thing -- the situation will get worse rather than better in the next five years.

It is the responsibility of the States to act to solve this crisis before it gets worse. Recovery will depend on reform. Medical cost and quality must be brought under control at the State level or else the Federal government may be forced to act in their place. The needed reforms will depend on cooperation, not name-calling, among all the concerned groups.

The States need to enact certain legal reforms to save the recovery rights of victims. Losses that cannot be measured must be capped to save our liability system from bankruptcy. Awards must be roughly in proportion to fault if deterrence is to be meaningful.

States should require better monitoring and control of incompetent and negligent medical personnel and better regulation of insurers to insure soundness and fair prices.

When parties can agree among themselves to use other ways to settle malpractice disputes than the expensive and time-consuming legal route, their right to do so should be protected.

These are the reforms that are needed now to solve the malpractice crisis. Similar measures are going to be necessary to bring the liability crisis for other services and products under control. We need to strengthen our legal system to protect victims' rights to recover, open the way for alternate ways to resolve disputes when the parties agree, and maintain quality control over products and services, including the insurance business.

99th CONGRESS
2d Session

H. RES. 386

To recommend to the States measures for medical cost and quality control.

IN THE HOUSE OF REPRESENTATIVES

March 5, 1986

Mr. Porter (for himself, Mr. Stark, Mr. Dornan of California, Mr. Gephardt, Mr. Gradison, Mr. Lewis of Florida, Mr. Madigan, Mr. Matsui, Mr. Miller of Ohio, and Mr. [illegible]) submitted the following resolution; which was referred jointly to the Committees on Ways and Means and Energy and Commerce

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RESOLUTION

To recommend to the States measures for medical cost and quality control.

Whereas increasing medical malpractice claims and mounting malpractice insurance costs are both diminishing the availability of medical care and increasing the cost of such care;

Whereas most of the expenditures made in response to alleged malpractice incidents are spent on litigation costs rather than on compensation to injured parties;

Whereas improved quality of medical services, reduced medical care costs, and actuarial predictability and insurability for medical liability risks can be achieved through a combination of tort reform, quality controls on medical care providers, and legal validation of alternate nontort systems for medical injury recovery in malpractice cases;

Whereas State laws and regulations establish the legal framework for medical liability actions and recoveries;

Whereas the Federal Government is directly concerned about unnecessarily high health-care costs because it pays 30 percent of the total health-care bills in the United States;

Whereas the Federal Government may require States that do not undertake necessary reforms implementing cost and quality control measures regarding medical malpractice to pay the Social Security taxes which they collect on behalf of their employees in a more timely fashion: Now, therefore, be it

Resolved, That, in order to improve the availability of medical care, to limit the incidence of medical malpractice, to control the direct and indirect costs of malpractice insurance and their impact on the Medicare Trust Funds, to validate alternative procedures for quickly resolving malpractice claims, and to strengthen the regulation of insurance, the States should adopt the following measures:

(1) Reforming state tort law.—

(A) Caps should be placed on the recovery of noneconomic losses in medical malpractice suits.

(B) The financial liability of parties bearing less than half the fault in a medical malpractice action should be proportionate to their degree of fault.

(C) The use of structured payouts should be required in cases involving large settlements or judgments.

(D) Duplicate payments from tort recoveries [illegible] sources should be eliminated.

(E) Statutes of limitation and allowable discovery periods should be short in order to balance the need to protect the victims of latent injuries and the need to reduce the high costs of insuring against uncertain risks far into the future.

(2) Reforming the monitoring and regulation of unprofessional and negligent conduct by health care professionals.—

(A) State agencies which license, certify, and discipline health care professionals should be strengthened by having access to information on malpractice actions for the purpose of identifying practitioners with aberrant practice patterns and by other means.

(B) Risk management programs acceptable to these State agencies should be implemented.

(C) Relevant State authorities should be granted access to insurance settlement information, with proper protection for individual patient confidentiality.

(D) State medical societies should be authorized to review malpractice complaints and actions, to take such responsible action as they deem appropriate in light of such review, and to report on such actions to State authorities.

(E) State medical societies should be allowed to perform the actions described in subparagraph (D) in confidence and should be exempted from antitrust prosecution for these actions.

(F) Hospital staffs should be authorized to review malpractice settlements and awards involving staff physicians and required to make a report of recommended action to the State medical board.

(G) Hospitals should be required to confirm the professional credentials and work history of physicians seeking staff privileges and should be granted immunity from antitrust and antidiscrimination suits should they deny staff privileges on the basis of unacceptable malpractice records.

(3) Reforming state contract law.—Contractual agreements entered into knowingly and willingly between health care providers and their patients to forego malpractice litigation in favor of alternative dispute resolution and claims settlement procedures should be enforceable and presumed valid under State law.

(4) Regulating insurance.—Insurance regulation should be strengthened by the States to protect consumers through assuring continued availability of commercial, pooled, or self-insured coverage at a fair price consistent with sound underwriting practices.

○

SCANIO, SCANIO, & BREEDEN
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MICHAEL E. SCANIO
VINCENT J. SCANIO, JR.
LEON BREEDEN

RECEIVED APR 9 1986

MAY 22 1986
Ways and Means
Subcommittee on Oversight

April 7, 1986

Representative J.J. (Jake) Pickle
300 East 6th
Austin, Texas 78701

Re: Liability Insurance Crisis

Dear Representative Pickle:

There has recently appeared in the press and in the news media a great deal of reporting concerning the so-called liability insurance "crisis." I have been following these reports with great interest and concern. I am writing at this time to share with you my thoughts on this matter, since I believe you will be asked to vote on proposed tort reform in the near future.

We do a wide range of both civil and criminal trial practice in this medium-sized, expanding, central Texas town. We have represented both plaintiffs and defendants in personal injury, products claims, and other tort actions. In our practice, we have seen both sides of litigation.

From the materials I have read and the reseach I have done, I feel that the entire attack upon our long-standing legal system in Texas by the insurance lobby is misleading and unjustified. During my thirteen years of practice here, I have seen similar attacks by the insurance lobby. In 1976, the insurance industry unsuccessfully attempted to change the whole field of medical malpractice by urging a crisis. In 1979, they attempted the same thing in the field of product liability. In reality, the awards and judgments do not back up their claims in any major Texas county. The insurance industry cut its rates in the late 1970's to chase the premium dollars to reinvest in the high interest markets. Now that those interest rates have fallen, they want to blame the legal system for their poor investment choices.

The vast majority of the injured clients we see and represent would have no lawyer if the contingent fee contract did not exist. These clients are not the parties complaining of the contingent fee, but rather the insurance industry that would prefer to see those claims go without redress.

I would urge you to vote for and would recommend that, before any steps are taken, there be a complete investigation of the accounting and investment procedures in the insurance industry for the past several years. They have produced their huge losses by paying dividends to their shareholders and counting these as losses, and reserving funds to pay claims as yet undecided.

Please have all the facts before voting on any issue of this nature. The proposed "reforms" would decimate the legal system and unjustly penalize the innocent for the poor business practices of the insurance industry. I will be glad to discuss this issue with you personally at any time.

Thank you for your help.

Sincerely,

SCANIO, SCANIO, & BREEDEN
A Professional Corporation

BY: ____________________
MICHAEL SCANIO

Statement of
JAMES H. GRUENWALD
NATIONAL EXECUTIVE DIRECTOR
SOCCER ASSOCIATION FOR YOUTH, U.S.A.

Mr. Chairman. Thank you for allowing me to submit this statement to your House Committee on this important topic. I am inserting this statement for the record in hopes of bringing relief to thousands of volunteers across America who are seriously threatened by this crisis and whose children will immensely suffer if volunteers cease their activities across America.

As background, The Soccer Association for Youth is a not-for-profit youth service agency which oversees 4600 youth soccer teams in twelve states with 70,000 boys and girls ages 5-18 participating annually. Our organizational chart consists of a 24 person board of directors, a three person full time executive staff, and local boards with 20,000 volunteer coaches, referees and administrators.

Our main function is to organize leagues, recruit and train coaches and officials, sponsor tournaments and prescribe rules and regulations for a safe, fun-filled experience for the children. Two main tenets of our program are that: (1) every child must be placed on a team; and (2) every child is guaranteed a minimum one half game participation/playing time. We have been in existence since 1967 and are proud to point out that we have NEVER had a claim filed against the organization or its members.

Our organization prides itself on excellence on the field, and our track record reflects that priority. We are, this year, pioneering a new concept: Risk Management Tips Cards. These handy cards will be a critical educational tool to make coaches and administrators aware of ways to minimize on site risks. We are constantly seeking ways to provide a quality program for our membership.

The current insurance crisis is threatening the very fabric of our program. Our insurance program in 1984 was $1 million general liability protection for everyone in our program at a cost of $4500 per year. In 1985, that same exact insurance coverage cost was $22,500 or a 493% increase. The best guestimates we have to date indicate a likelihood of at least $45-50,000 for these same coverages in 1986. We have already increased membership dues 25% in each of the past two years and are reluctant to continue to do so. It is pretty obvious that the member soccer clubs must either continue to pay these higher costs or drop out of the association.

Another issue that the liability insurance crisis spawns is a sudden exodus of quality persons serving on Boards of Directors at all levels; our limited coverages do not allay their fears that a megabuck award would adversely affect them financially as individuals. There is also a reluctance of volunteers to continue to give a few hours a week to help the children for fear of being sued from every corner. And even parents are hesitating to enroll their children in any programs that do not have liability insurance protection.

Our National Board of Directors realizes the dangers of not carrying liability insurance for itself as well as our valued volunteers in the field. But should these costs continue to escalate wildly, we will be forced to close up shop. Aside from the loss of the association from the scene, we will then see 70,000 youngsters in our program alone forced out of the sport because local clubs will lose their group purchasing power and not be able to afford insurance either. The multiplier effect on other associations and other sports agencies facing this same dilemma translates to the potential elimination of youth sports and agency activities such as Scouting, YMCA's, and Boys Clubs of America for over 60 million children nationally.

Congress must act soon to address this general liability crisis. I do not have any magic formulas or brilliant answers. But we must find ways to protect the volunteer spirit in this country. State and federal relief must address limited liabilities, bring punitive damage awards back in line, allow frivolous cases to be adjucated long before unnecessary legal expenses are entailed and eliminate the current extortion game which forces many premature settlements.

It is a shame that a "true accident" seemingly does not exist any longer. And without remedies, many worthwhile agencies will be forced to curtail their activities or cease operation entirely. The Soccer Association for Youth U.S.A. hopes to continue to fulfill our missions to over 70,000 youngsters nationally and know we speak for many of our counterparts as well.

Thank you very much for the children we serve.

SPALDING
SPALDING SPORTS WORLDWIDE
425 MEADOW STREET
P.O. BOX 901
CHICOPEE, MA 01021-0901
413-536-1200/TELEX NUMBER 955445

GEORGE A. DICKERMAN
President
Spalding Sports Worldwide

March 24, 1986

The Honorable
J.J. Pickle
Chairman, Subcommittee on Oversight
Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20515

Re: Hearings on the Costs and Availability of Liability Insurance

Gentlemen:

It is our purpose in this letter to formally endorse the position of the Sporting Goods Manufacturers Association as regards the product liability issue.

Though we have not suffered as much from the current product liability codes as have various of our competitors, we think that the result of having exited high risk categories more than we do of luck. In this regard Spalding completely exited the manufacture and sale of all protective equipment in 1975. This was a direct result of what we experienced and forecasted to be astronomically increased insurance costs as well as an enormous increases in the number of product liability suits.

Our decision was a financial one that in the interest of future corporate health had to be made. But make no mistake, our financial decision, the result of unbridaled product liability legislation, cost this company and this country several scores of manufacturing related jobs. Please do not make the further mistake of assuming that Spalding is or will be the only company forced to make such a decision. Jobs will continue to be lost, not for product related or manufacturing economy related reasons, but rather for all the wrong reasons - product liability suits have become an open gold mine so much so that the miners need not even borough in the ground of negligence to extract it. No negligence must be proved, rather, guilt by association with the sport seems to be enough to gather some of the gold.

If we do not act now to change the current legislation, then I believe our children will be playing these sports with either no protective equipment or with equipment so substandard as to present even higher health risks than playing with none.

We must present legislation that will correct a wrong but not penalize those who have acted reasonably and responsibly.

Sincerely,

George A. Dickerman

George A. Dickerman
President
Spalding Sports Worldwide

James G. Stockard
9135 Leghorn Place
Fairfax, Virginia 22031

RECEIVED
MAR 20 1986
Ways and Means
Subcommittee on Oversight

February 28, 1986

Dear Jake:

Shame on you for dealing with my plea of July 13 (outlawing production & importation of tobacco in all forms) as if it were just another LCD dirty trick!

Now I come with another plea . . . that you sponsor federal legislation which would re-cage the insurance industry, which is on the prowl devouring people and their resources.

Example 1: A company in Frost, Texas (Navarro Co.) cancelled (failed to renew) the coverage on my deceased parents' home. Other companies passed when asked to issue policies. The tenants had to vacate and the house stands without insurance.

Example 2: Enclosed art. from Wash. Post of 2/15/86 is self-explanatory. Please read this horror story! It is not about a town of 600 people, like Frost, but a modern urban community of Arlington, Va. with 180,000 or so people and a first-rate fire dept. Insurance quits tomorrow.

Example 3: See enclosed article about what Va. state delegate Bernie Cohen, of Alexandria, Va., is doing to protect citizens from the ravages of the insurance world.

Example 4: A neighbor here in Mantua Hills tells me that most of the vanpools are closing down because they can't get insurance. Obviously, a pleasanter way to commute to and from work than commercial buses.

Example 5: Several No. Va. communities 30-50 miles from D.C. have been pushing for a commuter train . . . on existing tracks with leased equipment. Why the uncertainty as to whether or not it will ever start? Because the insurance world is hesitant to take the risk. As if trains were invented yesterday.

Example 6: I know from being inside the Consumer Advisor Panel for a major insurance company (panel represents four states) that the industry is now thrashing higher risks out of their portfolios.

Jake, it is time for democracy to act as it did in the Philippines. Please do what you can.

Best personal wishes.

Jim

Alexandria, Virginia
Packet

February 13, 1986

Insurance reforms get nod

Conflict-of-interest of Delegates

Del. "Bernie" Cohen

Notes from Richmond

By Bernie Cohen

The house dealt with a hastily prepared conflict-of-interest bill to overcome a Supreme Court decision which would have left the General Assembly in a state of paralysis. Under the court's decision, substantial numbers of House members would not be able to vote on many measures. The bill passed by the House makes clear that only a direct and specific conflict of interest would prohibit a member's voting on a measure.

Spousal rape

One of the most interesting measures to be passed was the marital rape bill. The most important aspect of the bill would allow a spouse to be charged with rape if the couple lived apart and one member returned to the home of the other and forced the other to engage in intercourse or other intimate acts of sexual conduct. The bill also establishes a new crime of marital sexual assault for a spouse who forces the other to engage in sexual activity against his or her will, even where the couple is living together.

Blood alcohol level

The most debated measure during the session took place over the bill which makes it a crime to drive with a blood alcohol level of .10 or greater. Under the current law, the standard of .10 raises a presumption of guilt which may be rebutted by other evidence—the new bill, as passed by the House—deprives the accused of any right to show mitigating circumstances. It is known as a "per se" law. That is, the accused is guilty of a violation of law for violating the standard and no defenses are available except one to show that the .10 blood alcohol standard was not violated. The bill was supported by Governor Baliles, Attorney General Mary Sue Terry, many groups opposed to drunk driving and myself.

Insurance reform

I had a very successful v with my own legislation when House of Delegates passed si the bills which I introdu Among these were two insur reform bills which were a m part of my legislative agenda. bill will require that insur companies give reasonable no of cancellation or refusal to re insurance to businesses and fessionals. Homeowners and sumers already have similar tection under Virginia law.

The other insurance bill enable localities throughout state to form their own insura pool, and to have the state's Of of Risk Management adminis it. This is needed in response the crisis created by the insura industry which irresponsibly wi drew coverage from counti cities, towns and other politi subdivisions during the past ye These political subdivisions w now be able to join together form an insurance pool amo themselves and will probably sa a great deal of money, too.

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House Grows, Insurance Disappears

By Nancy Scannell
Washington Post Staff Writer

When a doctor told Jay and Luise Carver to expect a new baby next August, they decided to expand their one-story home in Arlington's Ashton Heights neighborhood because it already was too cramped for the family of four.

"We love the neighborhood and we don't want to move," Jay Carver said. "So we decided to build an addition." Others had done so in the neighborhood, which has attracted young families in pursuit of older, more affordable houses with big yards and roomy porches.

But unlike their neighbors, the Carvers found that their decision to stay put and add on has plunged them into a nightmare: State Farm Fire and Casualty Co. canceled their homeowner's insurance policy.

As a result, the couple has been unable to get other insurance and faces the possibility that a bank may foreclose on the home they bought 16 years ago.

According to State Farm, the moral of the Carvers' story is: Never make improvements to a house without first notifying and winning the approval of the insurance company. If you don't, your insurance may be cancelled and you may be branded with the "scarlet letter" of the industry—the refusal of other firms to insure the house.

"Do they [State Farm] mean a policyholder can't remodel the house? Apparently yes," said Carver, director of the District's Pretrial Services Agency, which makes background reports for courts on suspects seeking bail.

Citing State Farm's motto, "Like a good neighbor, State Farm is there," Carver added, "I don't know what neighborhood State Farm lives in, but no neighbor in Ashton Heights would treat their neighbor this way."

Peter Synnott, a deputy commissioner of the Virginia Bureau of Insurance, said he's never heard of a similar case and expects that the agency, which is an arm of the

See INSURANCE, E11, Col. 1

THE WASHINGTON POST SATURDAY, FEBRUARY 15, 1986 E11

Arlington Home Grows, Insurer Cancels Coverage

INSURANCE, From E1

State Corporation Commission, will investigate.

ynott said it is illegal for an insurance company to deny coverage to someone simply because another firm canceled a policy.

The Carvers' predicament began several weeks ago when they refinanced their home at 3406 N. 3rd St. to pay the estimated $80,000 it is costing to add a four-bedroom second story and about five feet onto the back of their house, which was appraised at $133,000.

The construction, which began about a month ago and is nearly completed, has transformed the pale-yellow wooden house from a tiny one-bath and two-bedroom structure with a sun porch into a five-bedroom, three-bath house with a large family room that was converted from one of the old bedrooms. At least two other homeowners in the neighborhood have added second stories to their houses.

The Carvers notified State Farm that the house was being refinanced and arranged with their local agent to upgrade their insurance coverage and premiums. But on Jan. 27, the Carvers received a letter from State Farm's regional office in Charlottesville along with their premium check.

Don Bragg, State Farm's chief underwriter at that office wrote that the company was not only refusing to upgrade the Carvers' policy but also was canceling it, effective March 1.

The reason: "Dwelling is currently undergoing remodeling. This is a greater exposure than that contemplated by our rate structure."

Bragg said in an interview that the ongoing renovation work had "significantly" increased the risks covered by the Carvers' policy and that it had begun without company knowledge or approval.

"It's one thing to finish off a downstairs family room and another to take a one-story house and make it a two-story house," Bragg said.

"Any time a significant change in risk is being made, the insurance company needs to be aware of it," he added. "A house that's undergoing remodeling has greater exposure to risk. . . . There are workers on the premises tearing out lines, more people around . . . a greatly increased liability."

He said that a house could be damaged structurally in such work, causing potential problems "down the road."

Bragg said that State Farm may not have canceled the Carvers' policy if they had waited until the work was finished before notifying the firm. But he warned that failure to notify the firm of ongoing work also could lead to a cancellation — a situation he acknowledged was a "Catch-22."

"This is incredible," said Carver, adding that the general contractor he hired has insurance to cover any possible liability arising from the remodeling. "As to any possible risk to the structure of the house, we've continued to live in it and we're not exposed" to extra risks, he said. The ceiling was in place in the three days it took to put on a new roof, he said.

Carver said he never made a claim or a late payment in the 16 years he has had State Farm home insurance. Despite that record, the Carvers' only recourse now, according to State Farm, is to apply for fire insurance through the Virginia Property Insurance Association, which operates an assigned-risk fund similar to those for accident-prone drivers.

Because that coverage would be limited, Carver said he contacted the Geico and Allstate insurance companies, where agents sympathized with him, but cited policies against insuring a person whose insurance had been canceled by another company.

Agents at those firms told a reporter they were surprised by State Farm's action and added that they doubted their firms would have done likewise. The agents also said they specifically advise clients to boost their coverage during construction work.

Jay Angoff, attorney for the Alexandria-based National Insurance Consumer Organization, said the Carvers have virtually no legal recourse. Insurance companies are exempt from federal antitrust legislation, and state laws offer no practical protection for homeowners caught in such binds, he said.

The Carvers, meanwhile, face the possibility of foreclosure on their home.

"Probably the next thing that I get in the mail will be a foreclosure notice," Carver said.

"The irony is that, if we sell the house after all this, the new owner wouldn't have any problems getting insurance," he said.

BOB WISE
3D DISTRICT, WEST VIRGINIA

COMMITTEES
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GOVERNMENT OPERATIONS
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RG

April 29, 1986

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Ways and Means
Subcommittee on Oversight

The Honorable J. J. Pickle
Chairman
Subcommittee on Oversight
Committee on Ways and Means
1105 Longworth Building
Washington, DC 20515

Dear Mr. Chairman:

I was recently made aware of the series of hearings that your Subcommittee is conducting on the liability insurance crisis. I would like to bring to your attention the pullout of malpractice insurers from the State of West Virginia and request that the Subcommittee on Oversight investigate this matter. What is ironic is that the state legislature enacted the first elements of tort reform sought by the insurance companies. Yet those companies object to providing more financial information to state regulators.

The insurance liability crisis is being felt all over the country. In West Virginia, four of the largest medical malpractice providers in the state recently announced they were canceling their policies. As of May 31, 1986, almost all of the state's doctors and hospitals will be without any malpractice insurance.

The involved insurance companies have taken exception to recently passed legislation by the West Virginia legislature. While enacting caps on recoveries for pain and suffering, the legislation also requires insurance companies to open their books for inspection. As a result, West Virginia is being used as a test case by the insurance industry to see if they can intimidate states into changing laws with which they do not agree.

I would appreciate any consideration your Subcommittee could give this problem. The West Virginia situation illustrates well the attitude of insurance companies to legislation asking them to supply more information to legislative bodies trying to grapple with the insurance dilemma.

Very truly yours,

Bob Wise

Bob Wise
Member of Congress

BW:ka

BOB WISE
3D DISTRICT, WEST VIRGINIA

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PUBLIC WORKS AND TRANSPORTATION
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June 16, 1986

The Honorable J. J. Pickle
Chairman
Subcommittee on Oversight
Committee on Ways and Means
1105 Longworth Building
Washington, DC 20515

Dear Mr. Chairman:

Since my previous correspondence to you concerning the malpractice insurance crisis in West Virginia a number of important events have unfolded. In fact, at this time the crisis has eased. Unfortunately, I feel this situation has been solved only in a short-term sense and will probably return to haunt West Virginia.

After the five insurance companies announced their decision to withdraw from West Virginia, the State filed suit in state court to have a preliminary injunction granted against their leaving. This injunction was denied by the Circuit Court but after an appeal to the West Virginia Supreme Court was granted on May 8, 1986. This was an important decision and it provided breathing room for the State Legislature.

The Legislature went into special session on May 15, 1986. There were a number of proposals on how to resolve the insurance crisis. Governor Arch Moore advocated that a state-operated insurance program be started for health care professionals. While there seemed to be a great deal of initial support for this proposal, the Legislature ultimately opted for a measure that would remove the objections the insurance industry had with the original bill.

The changes included the deletion of a non-renewal provision that specified when a company can refuse to renew policies. The bill also allowed disclosure of reserves and settlements in aggregate rather then individual policies. This compromise legislation was the result of meetings held by the leaders of the Legislature and the insurance companies.

I was not satisfied with the Legislature's solution to this crisis. While there has been a temporary easing in West Virginia, the real crisis still exists as long as the major insurance companies can dictate what regulation requirements they will accept. It should be pointed out that other states have enacted similar requirements but only West Virginia was singled out for economic retaliation.

I am grateful for your request for more information on the situation in West Virginia. The insurance companies actions in my state were one of the most offensive displays of economic power seen in a long time and I feel their actions are worthy of further investigation.

Very truly yours,

Bob Wise

Bob Wise
Member of Congress

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